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Involuntary Outpatient Commitment for the Chronically Mentally Ill

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Involuntary Outpatient Commitment for the Chronically Mentally Ill

TABLE OF CONTENTS

I. Introduction: The (Perceived) Need for Outpatient Commitment	346
II. Commitment to Outpatient Treatment	355
A. Outpatient Commitment or Conditional Release?	355
1. Conditional Release	356
2. Outpatient Commitment	358
B. Outpatient Treatment	361
1. Treatment Planning	361
2. Review	365
3. Right to Refuse Outpatient Treatment	367
III. Enforcement: Revocation of Outpatient Commitment	376
A. Statutory Procedures	376
B. Constitutional Requirements	380
C. Analysis	397
IV. Criteria for Involuntary Commitment	402
A. The Dangerousness Standard	402
B. A Lower Standard for Outpatient Commitment?	404
V. Conclusion: Summary and Recommendations	408

I. INTRODUCTION: THE (PERCEIVED) NEED FOR OUTPATIENT COMMITMENT

To correct the "abuses" of the psychiatrist's discretionary power in confining and releasing mental hospital patients, the legislatures and the courts have only two alternatives. One option is . . . to restrict the psychiatrist's powers to confine and release by assuming or arrogating more of these powers themselves. . . . Another option is the abolition of psychiatric imprisonment and the whole system of involuntary psychiatry.¹

Treatment for the chronically mentally ill has undergone marked changes in the past two decades. Public awareness of abuse and neglect of the mentally ill in large, isolated state and county institutions,

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1. Szasz, *Involuntary Psychiatry*, 45 U. CIN. L. REV. 347, 365 (1976).

new antipsychotic medications, and increasing involvement of the legal system in the care of the mentally disabled provided the impetus for the policies of deinstitutionalization² and community care³ as well as constitutional⁴ and statutory⁵ standards governing treatment and confinement.

The deinstitutionalization movement operated on the assumption that community care and freedom from the restrictiveness of total institutions are beneficial for the mentally ill.⁶ The goals of the deinstitutionalization movement included the development of a continuum of community-based services for the mentally disabled, including the chronically mentally ill; minimal use of institutions; treatment in the least restrictive settings;⁷ and preventive mental health care.⁸ Conse-

2. See, e.g., Bachrach, *An Overview of Deinstitutionalization*, in DEINSTITUTIONALIZATION (L. Bachrach ed. 1983).
3. See, e.g., ILL. ANN. STAT. ch. 91 1/2, para. 1-119(2)(Smith-Hurd 1987)(gives preference to care or treatment in the individual's home community).
4. E.g., clear and convincing standard of proof required in civil commitment proceedings (*Addington v. Texas*, 441 U.S. 418 (1979)); right to minimally adequate treatment (*Youngberg v. Romeo*, 457 U.S. 307 (1982)).
5. Approximately forty-two states provide for treatment of the mentally disabled in the least restrictive setting, Weiner, *Rights of Institutionalized Persons*, in THE MENTALLY DISABLED AND THE LAW 297 (Brakel, Parry & Wiener ed. 3d ed. 1985), twenty-five states require proof of dangerousness as well as mental illness for involuntary commitment; Brakel, INVOLUNTARY INSTITUTIONALIZATION, in *id.* at 34; and in most other states dangerousness is an alternative ground of commitment.
6. But see Minkoff, *Beyond Deinstitutionalization: A New Ideology for the Postinstitutional Era*, 38 HOSP. & COMMUNITY PSYCHIATRY 945, 946-47 (1987)("Freedom of choice and community living have often not made the lives of chronic patients better and easier. Given a choice, patients do not readily choose the identity of 'chronic mental patient' and thus have enormous difficulties making use of our programs to get the help they so desperately need").
7. The doctrine of the least restrictive alternative, or least restrictive environment or setting, refers to "the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services." THE PRESIDENT'S COMM'N ON MENTAL HEALTH, 1 REPORT TO THE PRESIDENT FROM THE PRESIDENT'S COMMISSION ON MENTAL HEALTH 44 (1978). The concept of a least restrictive alternative has been applied to legal status, *In re Farrow*, 41 N.C. App. 680, 255 S.E.2d 777 (N.C. Ct. App. 1979)(voluntary admission less restrictive than involuntary commitment); type of treatment, *Rogers v. Okin*, 634 F.2d 650, 655-56 (5th Cir. 1980)(balancing of competing interests in determining whether patient should be forcibly medicated "demands an individualized estimation of the possibility and type of violence, the likely effects of particular drugs on a particular individual, and an appraisal of alternative, less restrictive courses of action;" reasonable alternatives to the administration of antipsychotic drugs must be ruled out); locus of treatment, *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966)(en banc); *Stamus v. Leonhardt*, 414 F. Supp. 439 (S.D. Iowa 1976); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972)(community programs less restrictive than full-time institutionalization); and treatment settings within a hospital, *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969)(maximum security ward most restrictive). However, a treatment program must also be appropriate for each

quently, inpatient populations of public mental hospitals decreased, as did patients' mean length of stay.⁹ General and private psychiatric hospitals have been increasingly utilized to treat the mentally ill.¹⁰

Although there is some support for the belief that many seriously mentally ill patients can be successfully treated in the community with adequate treatment and support,¹¹ the goals of deinstitutionaliza-

patient's needs. See Bachrach, *Is the Least Restrictive Environment Always the Best? Sociological and Semantic Implications*, 31 HOSP. & COMMUNITY PSYCHIATRY 97, 100 (1980) (restrictiveness is associated with environmental factors, including location, staffing, programs and treatment provided, and degree of autonomy, which are not necessarily related to whether the patient lives independently in his own home, a halfway house, a hospital, or some other class of residential facility); Gutheil, Appelbaum & Wexler, *The Inappropriateness of "Least Restrictive Alternative" Analysis for Involuntary Procedures with the Institutionalized Mentally Ill*, 11 J. PSYCHIATRY & L. 7 (1983); Ransohoff, Zachary, Gaynor & Hargreaves, *Measuring Restrictiveness of Psychiatric Care*, 33 HOSP. & COMMUNITY PSYCHIATRY 361 (1982).

8. See, e.g., Mental Health Systems Act, Pub. L. No. 96-398, 94 Stat. 1564, 1601 & 1604 (1980), repealed by Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 902, 95 Stat. 357, 560 (1981); G. CAPLAN, PRINCIPLES OF PREVENTIVE PSYCHIATRY 110 (1964). But see Bachrach, *supra* note 2, at 98 ("Widespread belief in the goals of deinstitutionalization has frequently covered up an absence of consensus.").
9. See U.S. DEP'T OF HEALTH & HUMAN SERVICES, TOWARD A NATIONAL PLAN FOR THE CHRONICALLY MENTALLY ILL, REPORT TO THE SECRETARY BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES STEERING COMMITTEE ON THE CHRONICALLY MENTALLY ILL (1980) [hereinafter Health and Human Services Report] (number of residents in public mental hospitals was 559,000 in 1955; 504,000 in 1963; 216,000 in 1974; and 150,000 in 1980); De Risi & Vega, *The Impact of Deinstitutionalization on California's State Hospital Population*, 34 HOSP. & COMMUNITY PSYCHIATRY 140 (1983); Goldman, Adams & Taube, *Deinstitutionalization: The Data Demythologized*, 34 HOSP. & COMMUNITY PSYCHIATRY 129, 131 table 1 (1983) (public hospital resident population decreased from 558,922 patients in 1955 to 137,810 in 1980) and 134 (chronic mental patients continue to use inpatient psychiatric resources but length of stay has decreased and use of ambulatory services has increased); Klerman, *National Trends in Hospitalization*, 30 HOSP. & COMMUNITY PSYCHIATRY 110 (1979).
10. C. TAUBE & R. REDICK, DIVISION OF BIOMETRY AND EPIDEMIOLOGY, NATIONAL INSTITUTE OF MENTAL HEALTH, PROVISIONAL DATA ON PATIENT CARE EPISODES IN MENTAL HEALTH FACILITIES 1975 (Statistical Note 139 Aug. 1977) (proportion of inpatient and outpatient care episodes at state and county hospitals compared to private mental hospitals, general hospital psychiatric services, V.A. psychiatric inpatient services, and CMHC's reduced from 49% of total episodes in 1955 to 9% in 1975); Goldman, Adams & Taube, *supra* note 9; Kiesler & Sibulkin, *People, Clinical Episodes, and Mental Hospitalization: A Multiple-Source Method of Estimation*, in 2 ADVANCES IN APPLIED SOCIAL PSYCHOLOGY (R. Kidd & M. Saks ed. 1983).
11. See HEALTH AND HUMAN SERVICES REPORT, *supra* note 9, at 1-4 (study sponsored by the Commonwealth of Massachusetts Department of Mental Health showed that between 50% and 75% of admissions to the state's mental hospitals could be avoided if adequate community services were available) and at 2-5 (as many as two-thirds of patients currently residing in inpatient settings could be more appropriately treated in other, less protective settings); B. PASAMANICK, F.

tion have not been fully realized.¹² Because chronic individuals often remain underserved,¹³ many mentally ill former patients have become homeless or neglected in the community.¹⁴ Others have been "trans-institutionalized"¹⁵ into nursing homes, prisons, and jails.¹⁶

These problems have led to increasing public pressure—particu-

SCARPITTI & S. DINITZ, SCHIZOPHRENICS IN THE COMMUNITY: AN EXPERIMENTAL STUDY IN THE PREVENTION OF HOSPITALIZATION ix (1967)(experimental study confirmed hypothesis that "home care for schizophrenic patients is *feasible*, that the combination of drug therapy and public health nurses' home visitations is *effective* in preventing hospitalization, and that home care is at least as good a method of treatment as hospitalization by any or all criteria, and probably superior by most")(emphasis in original); ALTERNATIVES TO MENTAL HOSPITAL TREATMENT (L. Stein & M. Test eds. 1978); Becker & Schulberg, *Phasing Out State Hospital—A Psychiatric Dilemma*, 294 NEW ENG. J. MED. 255 (1976); Cohen, Sichel & Berger, *The Use of a Mid-Manhattan Hotel as a Support System*, 13 COMMUNITY MENTAL HEALTH J. 76 (1977); Dittmar & Franklin, *State Hospital Patients Discharged to Nursing Homes: How Are They Doing?*, 31 HOSP. & COMMUNITY PSYCHIATRY 255 (1980); Geller, *Rights, Wrongs, and the Dilemma of Coerced Community Treatment*, 143 AM. J. PSYCHIATRY 1259 (1986); Kiesler, *Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients*, 37 AM. PSYCHOLOGIST 349 (1982); Lamb & Goertzel, *The Long-Term Patient in the Era of Community Treatment*, 34 ARCHIVES GEN. PSYCHIATRY 679 (1977); Langsley, Machotka & Flomenhaft, *Avoiding Mental Hospital Admission: A Follow-Up Study*, 127 AM. J. PSYCHIATRY 1391, 1394 (1971); Mosher, Menn & Matthews, *Soteria: Evaluation of Home-Based Treatment for Schizophrenia*, 45 AM. J. ORTHOPSYCHIATRY 455 (1975); Polak & Kirby, *A Model to Replace Psychiatric Hospitals*, 162 J. NERVOUS & MENTAL DISEASE 13 (1976); Stein, Test & Marx, *Alternative to the Hospital: A Controlled Study*, 132 AM. J. PSYCHIATRY 517 (1975).

12. See Bachrach, *Evaluating the Consequences of Deinstitutionalization*, 34 HOSP. & COMMUNITY PSYCHIATRY 105 (1983); Slovenko, *The Past and Present of the Right to Treatment: A Slogan Gone Astray*, 9 J. PSYCHIATRY & L. 263, 272 (1981)("the mental hospital provides more of a community, especially for the disabled, than do our urban areas") and at 275 ("patients are not receiving the appropriate care or treatment in the inpatient or outpatient community alternatives"); Talbott, *Deinstitutionalization: Avoiding the Disasters of the Past*, 30 HOSP. & COMMUNITY PSYCHIATRY 621 (1979).
13. Goldman, Adams & Taube, *supra* note 9; Bachrach, *A Conceptual Approach to Deinstitutionalization*, 29 HOSP. & COMMUNITY PSYCHIATRY 573 (1978).
14. Chase, *Where Have All the Patients Gone?*, 2 HUMAN BEHAV. 10 (1973); Lamb, *Deinstitutionalization and the Homeless Mentally Ill*, 35 HOSP. & COMMUNITY PSYCHIATRY 899 (1984); Talbott, *supra* note 12.
15. Warren, *New Forms of Social Control: The Myth of Deinstitutionalization*, 8 AM. BEHAV. SCIENTIST 724 (1981); Talbott, *supra* note 12.
16. See I. KEILITZ, INSTITUTE ON MENTAL DISABILITY AND THE LAW, NATIONAL CENTER FOR STATE COURTS, A SUPPLEMENT TO THE NATIONAL CENTER FOR STATE COURTS GUIDELINES FOR INVOLUNTARY CIVIL COMMITMENT FOR FAMILIES AND FAMILY SELF-HELP ORGANIZATIONS (1987) [hereinafter IMDL SUPPLEMENT]; Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side Effects of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101 (1972); Slovenko & Luby, *On the Emancipation of Mental Patients*, 3 J. PSYCHIATRY & L. 191 (1975); Stelovich, *From the Hospital to the Prison: A Step Forward in Deinstitutionalization?*, 30 HOSP. & COMMUNITY PSYCHIATRY 618 (1979); Whit-

larly by family alliance groups for the mentally ill¹⁷—to relax commitment criteria so that involuntary treatment can be provided to more mentally ill individuals than are currently served.¹⁸ Two legislative bills introduced in the 1989 legislative session propose to broaden the group of candidates for involuntary commitment in Nebraska by making it easier to commit persons who are “likely to suffer substantial mental or physical deterioration” as the result of a “severe disorder.”¹⁹

Some commentators have blamed the shift from a medical model of treatment to a legal model²⁰ (which has strict commitment criteria and emphasizes patient rights) for the “denial” of treatment for mentally ill persons who are “obviously” in need of treatment.²¹ Descrip-

mer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 AM. J. ORTHOPSYCHIATRY 65 (1980).

17. See IMDL SUPPLEMENT, *supra* note 16; Treffert, *The Obviously Ill Patient in Need of Treatment: A Fourth Standard for Civil Commitment*, 36 HOSP. & COMMUNITY PSYCHIATRY 259, 261 (1985).

18. Treffert, *supra* note 17.

19. See L.B. 374, 91st Leg. Sess. (1989) and L.B. 732, 91st Leg. Sess. (1989). “Likely to suffer substantial mental or physical deterioration” is defined in both bills to mean:

[A]s evidenced by recent behavior, the person will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and such distress is associated with significant impairment of judgment, reason, or behavior, causing a substantial deterioration of his or her previous ability to function on his or her own.

“Severe mental disorder” means “an illness, disease, organic brain disorder, or other condition which (i) substantially impairs the person’s thought, perception of reality, emotional process, or judgment or (ii) substantially impairs behavior as manifested by recent disturbed behavior.” L.B. 374, § 1(2)(d), 91st Leg., 1st Sess. (1989) and L.B. 732, 91st Leg., 1st Sess. (1989).

20. See generally Morse, *A Preference for Liberty: The Case Against Involuntary Civil Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54 (1982). In general, medical models confer broad authority on mental health professionals under state *parens patriae* powers to hospitalize mentally ill persons deemed “in need of treatment.” Legal models emphasize safeguards to protect patients’ rights and limit coercive intervention and favor use of state police powers. See also Gutheil & Mills, *Legal Conceptualizations, Legal Fictions, and the Manipulation of Reality: Conflict between Models of Decision Making in Psychiatry and Law*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 17 (1982).

21. Treffert, *supra* note 17; IMDL SUPPLEMENT, *supra* note 16. But see Faulkner, Bloom & Kundahl-Stanley, *Effects of a New Involuntary Commitment Law: Expectations and Reality*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 249 (1982) (concerns of mental health professionals that new Arkansas law emphasizing due process and patients’ rights would prevent admissions to the state hospital, divert patients into the criminal justice system, force early release and cause revolving-door readmissions were not borne out); Haupt & Ehrlich, *The Impact of a New State Commitment Law on Psychiatric Patient Careers*, 31 HOSP. & COMMUNITY PSYCHIATRY 745, 749 (1980). Pennsylvania’s new commitment act “was expected to cause greater problems in committing a patient to inpatient care on an involuntary basis, [but] the study does not reflect this outcome.” A small but significant increase in involuntary admissions and in length of stay was attributed to a

tions of "revolving door" patients who fail to seek or continue outpatient treatment²² upon discharge from inpatient hospitalization have become common.²³ Without treatment, these individuals deteriorate in the community until they once again meet the commitment criteria²⁴ and are rehospitalized.

Continuity of care is essential in planning treatment programs for the chronically mentally ill.²⁵ The goals of brief hospital treatment are typically limited to controlling clinical symptoms and planning continued aftercare treatment.²⁶ In general, the use of outpatient psychiatric services has been associated with fewer readmissions and improved functioning.²⁷ Outpatient treatment compliance has also been found to be an important predictor of length of inpatient stays for pa-

greater frequency of admissions of patients who had been discharged against medical advice. The authors cite a study by the Philadelphia County Office of Mental Health and Mental Retardation which indicated the law had *facilitated* involuntary intervention, *id.* at 750, but following the change in the law, the proportion of discharges against medical advice increased, length of stay shortened, and recidivism rates were higher.

22. "Outpatient treatment" generally means any treatment program which does not require continuous inpatient hospitalization. *See, e.g.,* ARIZ. REV. STAT. ANN. § 36-501(25)(1986 & Supp. 1989).
23. *See, e.g.,* Bursten, *Posthospital Mandatory Outpatient Treatment*, 143 AM. J. PSYCHIATRY 1255 (1986); Cohen, Sichel & Berger, *supra* note 11; Hiday & Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT'L J. L. & PSYCHIATRY 215 (1987); IMDL SUPPLEMENT, *supra* note 16; Miller & Fiddleman, *Outpatient Commitment: Treatment in the Least Restrictive Environment?*, 35 HOSP. & COMMUNITY PSYCHIATRY 147 (1984); Trefert, *supra* note 17.
24. Many states require that mentally ill persons meet the criteria of danger to self, danger to others, or gravely disabled in order to be subject to involuntary civil commitment. *E.g.,* NEB. REV. STAT. § 83-1009 (1987).
25. Bachrach, *Continuity of Care for Chronic Mental Patients: A Conceptual Analysis*, 138 AM. J. PSYCHIATRY 1449 (1981). *See* Caton, Koh, Fleiss, Barrow & Goldstein, *Rehospitalization in Chronic Schizophrenia*, 173 J. NERVOUS & MENTAL DISEASE 139, 145 (1985) ("Failure to link the patient successfully to necessary community services can result in a rehospitalization very shortly after discharge.").
26. Caton & Gralnick, *A Review of Issues Surrounding Length of Psychiatric Hospitalization*, 38 HOSP. & COMMUNITY PSYCHIATRY 858, 859 (1987); Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275, 284 (1983) ("Modern psychiatric treatment at its best is geared to intensive short-term therapy, not to long-term hospital care.").
27. Caton, Koh, Fleiss, Barrow & Goldstein, *supra* note 25, at 144 (compliance with community treatment, interpersonal stress, and the adequacy of social supports were predictors of survivorship in the community; number of rehospitalization episodes was determined largely by the adequacy of discharge planning for aftercare treatment); Hafner & an der Heiden, *Effectiveness and Cost of Community Care for Schizophrenic Patients*, 40 HOSP. & COMMUNITY PSYCHIATRY 59 (1989). *See also* Goldstein & Horgan, *Inpatient and Outpatient Psychiatric Services: Substitutes or Complements?*, 39 HOSP. & COMMUNITY PSYCHIATRY 632 (1988).

tients who were readmitted.²⁸

However, many previously hospitalized patients are unwilling to seek outpatient treatment voluntarily,²⁹ and the dropout rate for outpatient treatment is high.³⁰ Given the importance of aftercare services in maintaining the chronically mentally ill in the community, it is not surprising that hospital readmission rates are also high.³¹ Because the presence of psychiatric symptoms may limit the ability of the mentally ill to use aftercare services,³² involuntary outpatient civil commitment is increasingly recommended for compelling treatment for those chronically mentally ill individuals—who have a history of failing to continue taking antipsychotic medication voluntarily or consistently and who, without medication, would predictably require inpatient hospitalization again in the future.³³

Proponents of outpatient commitment emphasize the potential for more effective treatment through addressing the individual's needs in coping with community life.³⁴ Some commentators argue that the current reactive, crisis-oriented approach is inappropriate in caring for the chronically mentally ill.³⁵ Outpatient treatment—so the theory goes—allows therapists to monitor clients' conditions and respond to changes which could precipitate deterioration.³⁶ Continuing outpa-

28. Caton, Koh, Fleiss, Barrow & Goldstein, *supra* note 25, at 145.

29. See Miller & Fiddleman, *supra* note 23.

30. See Pekarik, *Coping with Dropouts*, 16 PROF. PSYCHOLOGICAL RES. & PRAC. 114 (1985); Sue, McKinney & Allen, *Predictors of the Duration of Therapy for Clients in the Community Mental Health System*, 12 COMMUNITY MENTAL HEALTH J. 365 (1976) (of 13,450 clients seen in seventeen community mental health facilities, over 40% terminated treatment after one session).

31. Durham & La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, YALE L. & POL'Y REV. 101 (1985); Kiesler, *supra* note 11; Lewis & Hugi, *Therapeutic Stations and the Chronically Treated Mentally Ill*, 55 SOCIAL SERVICE REV. 206 (1981); Schwartz & Goldfinger, *The New Chronic Patient: Clinical Characteristics of an Emerging Subgroup*, 32 HOSP. & COMMUNITY PSYCHIATRY 470 (1981); Talbott, *Stopping the Revolving Door: A Study of Readmissions to a State Hospital*, 48 PSYCHIATRIC Q. 159 (1974) (sixty per cent of all admissions in three-month study were readmissions).

32. Goering, Wasylenki, Lancee & Freeman, *From Hospital to Community: Six Month and Two-Year Outcomes for 505 Patients*, 172 J. NERVOUS & MENTAL DISEASE 667 (1984).

33. Bursten, *supra* note 23; Geller, *supra* note 11; Hiday and Scheid-Cook, *supra* note 23; Miller and Fiddleman, *supra* note 23.

34. See Mulvey, Geller & Roth, *The Promise and Peril of Involuntary Outpatient Commitment*, 42 AM. PSYCHOLOGIST 571, 578 (1987), for discussion of the arguments in favor of and opposing involuntary outpatient commitment.

35. See Caton & Gralnick, *supra* note 26, at 860 (brief hospitalization may be the treatment of choice for nonchronic nonpsychotic patients); Geller, *supra* note 11, at 1262; Mulvey, Geller & Roth, *supra* note 34.

36. See G. CAPLAN, *supra* note 8, at 105 ("The major defect of the present system in most communities is that patients who are discharged from a mental hospital leave its jurisdiction and cease to be objects of administrative concern. . . .")

tient treatment could thereby prevent or reduce the need for inpatient hospitalization.³⁷

However, coerced treatment calls into question the proper balance among competing interests: the individual's interest in privacy, autonomy, and freedom from state intervention;³⁸ the family's interest in ensuring that a loved one receives needed treatment; and the state's interest in protecting citizens from dangerous mentally ill persons (police power commitments) and in caring for citizens who are unable to care for themselves (*parens patriae* commitments).³⁹ Questions about the limited efficacy of available treatment—especially when coerced—raise concerns that the infringement of liberty will accomplish only social monitoring functions.⁴⁰

Nebraska is among the states which permit involuntary commitment to outpatient treatment but are "silent on the myriad issues" involved.⁴¹ The lack of clear procedures and guidelines for outpatient commitment often results in infrequent use⁴² or inappropriate use⁴³ of

Although Dr. Caplan suggested continuing responsibility of hospital staff, he recognized that any changes in commitment laws must "safeguard the privacy of the citizen"; Goering, Wasylenki, Lancee & Freeman, *supra* note 32, at 672 ("Treatment with psychotropic medication requires frequent monitoring over long periods of time by someone who is familiar with the patient.").

37. See Bursten, *supra* note 23; Caton, Koh, Fleiss, Barrow & Goldstein, *supra* note 25, at 146 ("Careful monitoring of treatment and environmental predictors of rehospitalization at periodic intervals, beginning with discharge planning, might prevent a substantial number of readmissions to hospital for chronic schizophrenia."); Frances & Weiden, *Promoting Compliance with Outpatient Drug Treatment*, 38 HOSP. & COMMUNITY PSYCHIATRY 1158, 1160 (1987) (clinicians should maximize the chances of later compliance by a noncompliant patient. "The odds are high that [the patient] will return to the mental health care system only after a relapse. . . . [T]he patient and family should be advised about the early signs of relapse to help them seek help before dangerous events occur.").
38. Of course, treatment is assumed to be in the patient's interest also. See Treffert, *supra* note 17, at 264:

The freedom to be wandering the streets, psychotic, ill, deteriorating, and untreated, when there is a reasonable prospect of effective treatment, is not freedom; it is abandonment. The liberty to be naked in a padded cell in a county jail, hallucinating and tormented, without treatment that ought to be given is not liberty; it is another form of imprisonment. . . . The right to be seriously and obviously mentally ill but to have to deteriorate to being dangerous before treatment can be given is not a right; it is insensitivity, purism, and suspicion cruelly presented as concern.

39. IMDL SUPPLEMENT, *supra* note 16.
40. See Morse, *supra* note 20, at 67-68; Mulvey, Geller & Roth, *supra* note 34, at 575.
41. Keilitz & Hall, *State Statutes Governing Involuntary Outpatient Civil Commitment*, 9 MENTAL & PHYSICAL DISABILITY L. REP. 378 (1985).
42. See Hiday & Goodman, *The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness*, 10 J. PSYCHIATRY & L. 81 (1982).
43. See Hiday & Scheid-Cook, *supra* note 23. As Miller & Fiddleman, *supra* note 23, at 149 found, statutory guidelines alone may not be sufficient to prevent inappro-

outpatient commitment provisions. Despite a legislative mandate that committing mental health boards favor treatment alternatives, including commitment to outpatient treatment, over inpatient hospitalization,⁴⁴ outpatient commitment remains underutilized in Nebraska.

A study by Wood and Swanson⁴⁵ illustrates some of the reasons why outpatient commitment is rarely used in Nebraska. The authors reviewed the hospital charts of eighteen inpatients who were randomly selected from seventy-four patients who had been committed to a university-affiliated psychiatric hospital in the Omaha area during a three-year period. Four inpatients were not transferred to outpatient treatment because of insufficient response to short-term treatment, two needed an inpatient drug treatment program, and one patient requested to return to another hospital. Eight patients were transferred to a less restrictive partial hospitalization program. Of the three who were recommended for outpatient treatment, two did not keep initial appointments and one moved to another state.

The Institute on Mental Disability and the Law ("IMDL") of the National Center for State Courts, in *Guidelines for Involuntary Civil Commitment*, suggests that involuntary outpatient civil commitment should be used cautiously because "its goals are questionable and its implementation is problematic."⁴⁶

Administration of involuntary outpatient commitment as part of a general commitment scheme requires much more of the mental health-justice system than was required in times when a court order to commit invariably meant institutionalization. It requires, most importantly,

(i) careful selection of potential involuntary patients in accordance with the applicable legal criteria and prerequisites for outpatient commitment (only some involuntary patients will have the ability to follow a mental health treatment plan in the community);

priate placements ("even after the statutory changes designed to prevent inappropriate outpatient commitments, judges in the hearings we studied continued to order outpatient commitments for patients without the recommendation or even against the explicit recommendation of hospital and CMHC staff"). However, legal criteria and judicial discretion must be independent from, although based on consideration of, opinions of mental health professionals if legal proceedings are to have any significance beyond a judicial stamp of approval of psychiatric decisionmaking.

44. See NEB. REV. STAT. § 83-1038 (1987):

The disposition ordered by the mental health board shall represent the alternative which imposes the least restraint upon the liberty of the subject required to successfully treat the particular mental illness and prevent the particular harm which was the basis for the board's finding the person to be a mentally ill dangerous person. The board shall consider all treatment alternatives . . . including outpatient treatment. . . . Full-time inpatient hospitalization or custody shall be considered a treatment alternative of last resort.

45. Wood & Swanson, *Use of Outpatient Treatment During Civil Commitment: Law and Practice in Nebraska*, 41 J. CLINICAL PSYCHOLOGY 723 (1985).

46. IMDL SUPPLEMENT, *supra* note 16, Guideline G2.(a).

- (ii) commitment courts that are thoroughly familiar with the continuum of services available in the community;
- (iii) available alternatives to hospitalization that meet the legal, fiscal, and practical requirements of outpatient commitment orders;
- (iv) adequate resources for respondents' supervision while in outpatient status;
- (v) organizational arrangements and procedures for the monitoring and review of the respondent's compliance with the conditions of outpatient commitment; and
- (vi) fair and workable rules and procedures for revoking outpatient commitment when necessary.⁴⁷

This article discusses many of the issues which should be addressed in formulating a comprehensive policy of outpatient commitment. Section II describes conditions of outpatient treatment and the differences between outpatient commitment and conditional release statutes. In section III, statutory procedures are reviewed and due process requirements for enforcing an order of outpatient commitment when an outpatient fails or refuses to follow prescribed treatment are discussed. Finally, section IV considers the appropriate standard for outpatient commitment.

II. COMMITMENT TO OUTPATIENT TREATMENT

A. Outpatient Commitment or Conditional Release?

In most states, statutory provisions for outpatient commitment have not been widely used⁴⁸—undoubtedly due, in part, to the confusion and lack of knowledge about procedures and parameters of statutory authority.⁴⁹ Involuntary outpatient treatment may be ordered as a dispositional alternative to inpatient hospitalization pursuant to statutes which authorize or permit outpatient commitment or treatment, or statutes which require treatment in the least restrictive alternative setting.⁵⁰ Alternatively, involuntary outpatient treatment may be ordered following a period of inpatient treatment, utilizing statutes which provide for outpatient commitment, convalescent leave, parole, or conditional release from inpatient treatment.

47. *Id.*

48. See J. OWENS, DIVISION OF EDUCATIONAL SERVICES SYSTEMS LIAISON OF THE NATIONAL INSTITUTE OF MENTAL HEALTH, INVOLUNTARY OUT-PATIENT COMMITMENT: AN EXPLORATION OF THE ISSUES AND ITS UTILIZATION IN FIVE STATES (1985) [hereinafter INVOLUNTARY OUT-PATIENT COMMITMENT].

49. See Miller, *Commitment to Outpatient Treatment: A National Survey*, 36 HOSP. & COMMUNITY PSYCHIATRY 265 (1985) (survey results showed significant disagreement between state attorneys general and mental health directors regarding whether involuntary outpatient commitment was permitted in their state).

50. ALASKA STAT. § 47.30.755(b)(1984) ("If the court finds that there is a less restrictive alternative available and that the respondent has been advised of and refused voluntary treatment through the alternative, the court may order the less restrictive alternative treatment after acceptance by the program of the respondent for a period not to exceed 90 days.").

1. *Conditional Release*

Approximately forty states have statutory provisions for conditional release of an improved mentally ill patient from the hospital to the community.⁵¹ Continuation of the release is dependent upon compliance with certain conditions; often the individual must receive follow-up care at the institution, or from a local clinic or psychiatrist. Most state statutes do not specify the conditions which the patient must follow when released,⁵² and allow the treatment facility to formulate an individualized treatment plan which "may include any conditions which the head of the treatment facility considers to be in the best interests of the patient or necessary to ensure that the patient is not likely to cause harm to self or others."⁵³ Some states require outpatient treatment as a condition for early release⁵⁴ or specifically require the taking of medication.⁵⁵ Connecticut allows placement in a private boarding home for mentally ill patients or a "chronic and convalescent hospital," provided the patient remains subject to the medical supervision of the superintendent or director of the releasing facility.⁵⁶ In Colorado, the professional in charge of providing short-term treatment may prescribe day care, night care, "or any other similar mode of treatment" prior to termination of the treatment.⁵⁷

Upon release, the patient is provided a copy of the conditions which she must follow to remain in the community⁵⁸ and sometimes must sign a written agreement.⁵⁹ If the patient fails to adjust to community life or to comply with the conditions of release, she may be reinstitutionalized.⁶⁰ Similarly, a patient granted convalescent leave⁶¹ or status⁶² is permitted to live outside the hospital, but is not legally or unconditionally discharged. Other statutory terms for conditional re-

51. Brakel, *Discharge and Transfer in THE MENTALLY DISABLED AND THE LAW*, *supra* note 5, at 203.

52. *Id.* at 206.

53. KAN. STAT. ANN. § 59-2924(d)(1983 & Supp. 1989).

54. See IDAHO CODE § 66-338 (1980 & Supp. 1990); MONT. CODE ANN. § 53-21-183 (1990) ("When, in the opinion of the professional person in charge of a mental health facility providing involuntary treatment, the committed person can be appropriately served by outpatient care prior to the expiration of the period of commitment, then outpatient care may be required as a condition for early release. . . .").

55. *E.g.*, WIS. STAT. ANN. § 51.20(13)(dm)(West 1987 & Supp. 1989).

56. CONN. GEN. STAT. ANN. § 17-191 (West 1988).

57. COLO. REV. STAT. § 27-10-110(1)(1989).

58. See, *e.g.*, ALASKA STAT. § 47.30.795(b)(1984); ARIZ. REV. STAT. ANN. § 36-540.01.C (1986 & Supp. 1989); OR. REV. STAT. § 426.278(1)(1989).

59. See UTAH CODE ANN. § 62A-12-241(1)(1989).

60. See, *e.g.*, N.C. GEN. STAT. § 122C-277(a)(1989). See *infra* Section III. B. regarding the constitutionality of rehospitalization procedures.

61. *E.g.*, NEV. REV. STAT. § 433A.380 (1981).

62. *E.g.*, N.M. STAT. ANN. § 43-1-21 (1984).

lease of hospitalized mentally ill patients include temporary release,⁶³ interim community leave,⁶⁴ provisional discharge,⁶⁵ trial visit,⁶⁶ furlough,⁶⁷ parole,⁶⁸ and conditional outpatient treatment.⁶⁹

The distinction between conditional release and outpatient commitment is often a fine one,⁷⁰ but it is an important one which may

63. ILL. ANN. STAT. ch. 91 1/2, para. 3-902(e)(Smith-Hurd 1987).

64. MASS. GEN. LAWS ANN. ch. 123, § 4 (West 1986 & Supp. 1990).

65. MINN. STAT. ANN. § 253B.15(1) & (2)(West 1982 & Supp. 1990).

66. OHIO REV. CODE ANN. § 5122.22 (Anderson 1981); OR. REV. STAT. § 426.273(2) (1987).

67. TEX. REV. CIV. STAT. ANN. art. 5547-69 (Vernon Supp. 1990).

68. N.J. STAT. ANN. § 30:4-107 (West 1981)(repealed 1987).

69. ARIZ. REV. STAT. ANN. § 36-540.01 (1986).

70. The distinction between conditional release and outpatient commitment becomes blurry in states such as Wisconsin, where the court may order commitment to outpatient treatment under the care and custody of a county department. The court also designates the facility or service. WIS. STAT. § 51.20(13)(a)(3)(1989). However, the court order directs the county department to release the individual on a *conditional transfer* in accordance with the statutory provisions for conditional release from inpatient treatment. *Id.* at § 51.20(13)(dm). The order provides that the director of the inpatient facility may request that the individual be taken into custody by a law enforcement agency upon noncompliance. Because the director of the inpatient facility has broad discretion to act without further court authorization or judicial hearing, this procedure would be considered a conditional release, even though the court issues the initial order and even though the individual may be committed to outpatient treatment initially, and is not necessarily released from inpatient treatment.

Similarly, Tennessee allows the discharge of an inpatient "subject to the obligation to participate in any medically appropriate outpatient treatment." TENN. CODE ANN. § 33-6-201(b)(2)(1984 & Supp. 1989). Unless judicial review of the outpatient treatment plan is requested, the court is not involved unless a hearing is required upon noncompliance (*see generally infra* Section III.A.) and the hospital notifies the court of the discharge to outpatient treatment. *Id.* at § 33-6-201(d). Following a hearing, the patient may be "re-committed" by the court "to the hospital from which the patient was released." *Id.* at § 33-6-203(d). The outpatient treating professional terminates the treatment obligation and notifies the court and hospital which discharged the patient. *Id.* at § 33-6-207. The treating professional may also renew the outpatient treatment obligation for six months if the outpatient continues to meet the criteria for outpatient treatment after six months. *Id.* Because this procedure is initiated and terminated by treatment personnel and a noncomplying outpatient is returned to the hospital, this statutory scheme would also be considered a conditional release mechanism, with some judicial intervention to safeguard patient rights and enforce patient obligations.

In Oregon, the distinction seems to revolve around who will care for the outpatient. Conditional release may be ordered by a court if requested by a legal guardian, relative, or friend of the mentally ill person who has the ability and resources to care for the individual. OR. REV. STAT. § 426.125 (1989). If the court commits the individual to the Division of Mental Health, the Division may place the individual in outpatient commitment, but only if an adequate treatment facility is available. *Id.* at § 426.130(C)(ii), 426.127(1). Conditional release or commitment may be ordered for up to 180 days. *Id.* at § 426.130(2). Further, if the individual is committed to the Division and placed in inpatient treatment, the Division "may grant a trial visit to the patient for a period of time and under any

affect decisionmaking authority, the stage at which the outpatient treatment is provided, and enforcement mechanisms. Conditional release provisions presume initial inpatient hospitalization, with release to outpatient status generally resting solely in the discretion of the director or superintendent of the inpatient facility or the attending physician.⁷¹ The patient is legally committed to the inpatient facility, but is conditionally released for treatment in the community.⁷² Conditional release procedures are thus hospital-oriented and, often, the outpatient can be rehospitalized at the discretion of treatment personnel⁷³ and without formal proceedings or judicial review.⁷⁴

2. Outpatient Commitment

Under outpatient commitment statutes, a mentally ill individual may be committed to outpatient treatment following a period of institutionalization, as under conditional release provisions.⁷⁵ An individ-

conditions the division shall establish . . . if the trial visit is agreed to by the community mental health and developmental disabilities program director. . . ." *Id.* at §§ 426.273(1). Conditional release, outpatient commitment and trial visits are all subject to the same procedure if the outpatient fails to adhere to the conditions of outpatient treatment. *See id.* at § 426.275. *See also infra* notes 180-81 & accompanying text.

71. *See, e.g.,* ARIZ. REV. STAT. ANN. § 36-540.01.B (1986 & Cum. Supp. 1989); MO. REV. STAT. § 632.385 (1986 & Supp. 1990); N.C. GEN. STAT. § 122C-277(a)(1989). *But see* OR. REV. STAT. § 426.130(2)(1989) (court orders conditional release and establishes a period of commitment up to 180 days).
72. *See* N.J. STAT. ANN. § 30:4-107 (West 1981)(patients placed in family care remain patients of the institution until discharged)(repealed 1987); WIS. STAT. § 51.20(13)(f)(1987 & Supp. 1989).
73. *See* ARIZ. REV. STAT. ANN. § 36-540.01(I)(1986 & Supp. 1989)("The medical director may rescind an order for conditional outpatient treatment and order the patient to return to a mental health treatment agency at any time during the period of court ordered treatment if, in the medical director's judgment, the patient has failed to comply with a term of the outpatient treatment plan or if, for any reason, the patient needs inpatient treatment"). *See also* N.Y. MENTAL HYG. LAW § 29.15(e)(McKinney 1988).
74. *See, e.g.,* ALASKA STAT. § 47.30.795(c)(1984); KAN. STAT. ANN. § 59-2924(d)(1983 and Supp. 1990)("If the patient fails to comply with any conditions of the treatment plan, the head of the facility may revoke the release and order the patient readmitted to the facility. The head of the facility may authorize and order a law enforcement officer or other person to take into custody and transport the patient to a treatment facility"). *But see* WASH. REV. CODE ANN. § 71.05.340(b)(3)(Supp. 1990)("the designated county mental health professional or the secretary may order that the conditionally released person be apprehended and taken into custody and temporarily detained in an evaluation and treatment facility . . . until such time, not exceeding five days, as a hearing can be scheduled to determine whether or not the person should be returned to the hospital").
75. *See* GA. CODE ANN. § 88-506-5(a)(Harrison Supp. 1989); MONT. CODE ANN. § 53-21-182 (1989); N.C. GEN. STAT. § 122C-274(f), 122C-277(a)(1989)(if attending physician determines a respondent meets the outpatient commitment criteria, the physician may request a supplemental hearing, at which the court may continue the original inpatient commitment, order outpatient commitment for up to ninety

ual also may be committed to outpatient treatment in an initial order, as a dispositional alternative to inpatient hospitalization.⁷⁶ The outpatient is legally committed to the outpatient facility or the care of the psychiatrist responsible for supervision of the outpatient treatment, not to an inpatient facility where he may or may not have previously received treatment.⁷⁷ Outpatient commitment statutes are community-oriented and, frequently, more "legally" oriented than conditional release provisions in that the outpatient treatment plan often must be judicially approved.⁷⁸ Outpatient staff are responsible for notifying the committing agency⁷⁹ when an outpatient is not complying with outpatient treatment or when inpatient treatment is clinically indicated.⁸⁰

Noncompliance with the outpatient program does not usually result in automatic return to inpatient hospitalization.⁸¹ For example, in Hawaii—which has a separate statutory procedure for outpatient commitment—a separate petition for involuntary hospitalization may be filed in the event of noncompliance.⁸² If the outpatient commitment is successfully completed, the individual is automatically discharged unless another petition is filed. In addition, the outpatient treatment professional may terminate the outpatient treatment if she determines the outpatient is no longer a mentally ill person requiring involuntary treatment.⁸³

days, or dismiss the case); MICH. COMP. LAWS ANN. § 330.1472 (2)(b), (3)(b) (West 1980 & Supp. 1990) (if a patient is hospitalized under a 60-day or 90-day order of hospitalization and continues to require treatment, the court may order alternative treatment or a combination of hospitalization and alternative treatment for a period of not more than one year).

76. See, e.g., ARIZ. REV. STAT. ANN. § 36-540.A (Supp. 1989); ILL. ANN. STAT. ch. 91 1/2, para. 3-812(a) (Smith-Hurd 1987) (if an individual is found subject to involuntary admission but not in need of hospitalization, the court may order the person admitted to a program of alternative treatment. The program must be "capable of providing adequate and humane treatment which is appropriate" for the individual's condition); MICH. COMP. LAWS ANN. § 330.1469(3) (West 1980 & Supp. 1990).

77. E.g., HAW. REV. STAT. §§ 334-127, 334-129 (1985). In Oregon, the individual is committed to the Division of Mental Health, which may place him in outpatient commitment if placement is available. OR. REV. STAT. §§ 426.130(C), 426.127(1) (1989).

78. E.g., ARIZ. REV. STAT. ANN. § 36-540.B.2 (1986 & Supp. 1989).

79. "Committing agency" is used to refer to the court or mental health commitment board which is responsible for issuing orders for involuntary civil commitment in accordance with state law.

80. MICH. COMP. LAWS ANN. § 330.1469(8) (West 1980 & Supp. 1990); TEX. REV. CIV. STAT. ANN. art. 5547-52(c) (Vernon Supp. 1990).

81. E.g., HAW. REV. STAT. § 334-129(c) (1985). But see ARIZ. REV. STAT. ANN. § 36-540.d.4 (1986 & Supp. 1989); MICH. COMP. LAWS ANN. § 330.1469(9) (West 1980 & Supp. 1990); N.D. CENT. CODE § 25-03.1-21 (1989). See also *infra* Section III.A. for discussion of statutory procedures upon noncompliance with outpatient treatment.

82. HAW. REV. STAT. § 334-129(c) (1985).

83. GA. CODE ANN. § 88-512(b) (Harrison Supp. 1989).

Just as definitions of outpatient commitment vary, treatment provided to committed outpatients lacks a standard definition. Hawaii's outpatient commitment statute defines outpatient treatment to include medication authorized by court order, individual or group therapy, day programming activities, "services and training, including educational and vocational activities," supervised living arrangements, and "any other services prescribed to either alleviate the person's disorder or disability, to maintain semi-independent functioning, or to prevent further deterioration that may reasonably be predicted to result in the need for hospitalization."⁸⁴ Georgia defines outpatient treatment as "a program of treatment for mental illness outside a hospital facility setting which includes, without being limited to, medication and prescription monitoring, individual or group therapy, day or partial programming activities, case management services, and other services to alleviate or treat the patient's mental illness so as to maintain the patient's semi-independent functioning and to prevent the patient's becoming an inpatient."⁸⁵ In Mississippi, alternatives to inpatient commitment may include, but are not limited to, voluntary or court-ordered treatment with specific reference to a treatment regimen, day or night treatment in a hospital, placement in the custody of a friend or relative, or the provision of home health services.⁸⁶ Texas allows a judge to order a person to participate in outpatient mental health services, including "programs of community mental health and mental retardation centers and services provided by a private psychiatrist or psychologist."⁸⁷ Wood and Swanson⁸⁸ described an outpatient program in Nebraska which provided only medication.

Conditional release and outpatient commitment are not mutually exclusive procedures; a state may appropriately provide for both if each is clearly defined. For example, in North Carolina, if a court finds that an individual meets the criteria for outpatient commitment,⁸⁹ involuntary outpatient treatment or a combination of inpatient and outpatient treatment may be ordered for up to ninety days.⁹⁰ If an inpatient's attending physician determines that the patient meets the criteria for outpatient commitment, the physician may request a

84. HAW. REV. STAT. § 334-122(c)(1985).

85. GA. CODE ANN. § 88-501(12.2)(Harrison Supp. 1989).

86. MISS. CODE ANN. § 41-21-73(4)(Supp. 1990).

87. TEX. REV. CIV. STAT. ANN. art. 5547-51(d)(2)(Vernon Supp. 1990).

88. Wood & Swanson, *supra* note 45, at 727 (adult outpatient service of a university-affiliated psychiatric hospital in the Omaha area).

89. *See infra* note 334.

90. N.C. GEN. STAT. § 122C-271(a)(1), (b)(1),(2)(1989). Other states which allow commitment to outpatient or combined inpatient and outpatient treatment include Arizona (ARIZ. REV. STAT. ANN. § 36-540.A.2 (1986 & Supp 1989)); Georgia (GA. CODE ANN. § 88-506.2 (Harrison Supp. 1989)); Michigan (MICH. COMP. LAWS ANN. § 330.1468(2)(c),(d),(3)(c),(d)(West 1980 & Supp. 1990); and Pennsylvania (PA. STAT. ANN. tit. 50, § 7304(f)(Purdon Supp. 1989).

supplemental hearing (in which case the court decides the issue), or the physician may release the patient for periods of up to thirty days "on specified medically appropriate conditions."⁹¹

As currently written, Nebraska statutes seem to provide for conditional release (the mental health board may hold a hearing to determine whether "a person who has received mental health board-ordered treatment is adhering to the conditions of his or her release from treatment, including the taking of medication"⁹²) as well as convalescent leave (the superintendent must notify the mental health board when a nonvoluntary patient is ready for discharge or convalescent leave⁹³) and outpatient commitment—both as a less restrictive alternatives in the initial order (the mental health board shall consider all treatment alternatives, including outpatient treatment⁹⁴) and following inpatient treatment (if a less restrictive alternative exists, the mental health board shall change the treatment disposition⁹⁵). However, the Nebraska Mental Health Commitment Act fails to provide specific procedures or guidelines concerning such issues as who bears responsibility for informing the board of the availability and appropriateness of treatment alternatives, what is the board's role in conditional release or convalescent leave, how compliance with outpatient treatment should be monitored, who has enforcement authority, and what is the permissible length of outpatient treatment.

Legislative Bill 723, currently before the Nebraska Unicameral, proposes to amend Neb. Rev. Stat. 83-1062 to include the following definition of outpatient treatment:

Sec. 3. Outpatient treatment shall mean a mental health board order directing a person to comply with specified treatment requirements, not involving the continuous supervision of the person in a residential setting, that are reasonably designed to alleviate or reduce the person's illness or disability or to maintain or prevent deterioration of the person's mental or emotional functioning. The specified requirements may include, but need not be limited to, (a) taking prescribed medication, (b) reporting to a facility for treatment or to permit monitoring of the person's condition, or (c) participating in individual or group therapy or educational or vocational programs.⁹⁶

B. Outpatient Treatment

1. Treatment Planning

The distinction between hospital-oriented and community-oriented outpatient statutes is also reflected in treatment planning. Condi-

91. N.C. GEN. STAT. § 122C-277(a)(1989). NEB. REV. STAT. § 83-1080 (1987).

92. NEB. REV. STAT. § 83-1080 (1987).

93. *Id.* at § 83-340.01.

94. *Id.* at § 83-1038.

95. *Id.* at § 83-1046.

96. See *infra* notes 150 and 202 regarding other provisions of L.B. 723, 92d Leg., 2d Sess. (1990).

tional release statutes often provide for formulation and modification of the treatment plan by the institution releasing the patient. For example, in Kansas the outpatient facility must inform the head of the releasing facility of any material noncompliance with the treatment plan, and it is the head of the inpatient facility who may change the treatment plan or the specified conditions.⁹⁷ In Arizona, the medical director issues the order for conditional outpatient treatment (which includes an outpatient treatment plan prepared by inpatient staff), and the director may amend the plan during outpatient treatment.⁹⁸ This approach may be desirable insofar as a treatment team has determined the medication regimen most beneficial to the individual, particularly if the subject will receive outpatient treatment at the same facility or with the same psychiatrist or staff who provided inpatient treatment. However, such laws fail to consider that, upon release, many patients return home to a different community, and treatment will be continued at a local community mental health center. Secondly, if the individual was hospitalized only briefly, long-term treatment effects may not be evident. The individual's new therapist is in a better position to determine the client's continuing needs. Thirdly, statutes which make the director of the inpatient facility responsible for a patient receiving outpatient treatment⁹⁹ may cause a reluctance to release patients as early as may be possible or desirable, particularly if the outpatient treatment continues at a different facility or in a different community from the inpatient facility.

Several states' conditional release statutes require that an initial outpatient treatment plan be developed in cooperation with both the original inpatient facility and the outpatient facility or physician responsible for outpatient care.¹⁰⁰ The Texas statute also includes consultation with the patient.¹⁰¹ The Montana and Tennessee statutes provide that the outpatient facility or the professional in charge of the

97. KAN. STAT. ANN. § 59-2924(d)(1983 & Supp. 1989). *See also* WIS. STAT. ANN. § 51.20(13)(b)(2),(dm)(West 1987 & Supp. 1990).

98. ARIZ. REV. STAT. ANN. § 36-540.01 (1986 & Supp. 1989).

99. *E.g.*, MO. REV. STAT. § 632.385(1)(Supp. 1990) ("Release to the least restrictive environment shall include provisions for continuing responsibility to and by the facility"); N.M. STAT. ANN. § 43-1-21(A)(1989) ("Release on convalescent status shall include provisions for continuing responsibility to and of the hospital"); WIS. STAT. ANN. § 51.20(13)(f)(West 1987 & Supp. 1990) ("The county department shall have ongoing responsibility to review the individual's needs" when an individual is released on a conditional transfer and placed in a treatment program). *But see* FLA. STAT. ANN. § 394.469(3)(West 1986) ("Placement on convalescent status shall include provisions for continuing responsibility by a professional or facility in the community"); W. VA. CODE § 27-7-2 (1986) ("Release on convalescent status shall include provisions for continuing responsibility to and by a mental health facility, not necessarily the facility in which the patient was previously hospitalized").

100. *E.g.*, S.D. CODIFIED LAWS ANN. § 27A-14-13 (1984); TENN. CODE ANN. § 33-6-201(b)(2)(1984 & Supp. 1990).

101. TEX. REV. CIV. STAT. ANN. art. 5547-67(a)(Vernon Supp. 1990).

patient's case may modify the treatment plan or place of treatment when the patient has been conditionally released.¹⁰²

Under outpatient commitment statutes, the court is often required to designate in the commitment order the outpatient treatment center or psychiatrist who will provide or supervise outpatient treatment.¹⁰³ Texas requires the individual responsible for court-ordered outpatient services to submit a "general program of treatment" within two weeks of the court's order of outpatient commitment.¹⁰⁴ The treatment program is then incorporated into the court's order. Whether the initial plan is developed by the inpatient or evaluating facility alone,¹⁰⁵ in cooperation with the outpatient facility,¹⁰⁶ or by the outpatient facility,¹⁰⁷ the plan should incorporate the experience of the inpatient facility in treating the patient, and provide for modifications as needed by the designated outpatient psychiatrist or facility. The committing agency should be notified of substantial changes in the treatment plan,¹⁰⁸ with judicial review available when warranted.¹⁰⁹ If the modification involves a change in treatment facility or psychiatrist, the committing agency should make or approve the change.¹¹⁰

The individualized¹¹¹ treatment plan should be comprehensive and address the mental and physical needs of each patient, including medication, psychotherapy, housing, employment, and special needs.¹¹²

102. MONT. CODE ANN. § 53-21-183(2)(1990); TENN. CODE ANN. § 33-6-201(e)(Supp. 1990). See also OR. REV. STAT. § 426.273(5)(1989) ("the director of the community mental health program . . . may modify the conditions for continued trial visit").

103. E.g., MICH. COMP. LAWS ANN. § 330.1469(5)(West 1980 & Supp. 1990); N.C. GEN. STAT. §§ 122C-267(h), 122C-271(b)(4)(1989).

104. TEX. REV. CIV. STAT. ANN. art. 5547-52(b)(Vernon Supp. 1990).

105. See ILL. ANN. STAT. ch. 91 1/2, para. 3-810 (Smith-Hurd 1987)(preliminary plan prepared prior to disposition).

106. GA. CODE ANN. § 88-509(b)(Harrison Supp. 1989)(the "referring facility" shall prepare an individualized service plan for the patient in consultation with the "receiving facility").

107. OR. REV. STAT. § 426.127 (1989).

108. See, e.g., TEX. REV. CIV. STAT. ANN. art. 5547-52(c)(Vernon Supp. 1990).

109. See *id.* at art. 5547-53(a). See also TENN. CODE ANN. § 33-6-201(c)(1984 & Supp. 1990)(outpatient may request judicial review of treatment plan within forty-eight hours).

110. See TEX. REV. CIV. STAT. ANN. art. 5547-53 (Vernon Supp. 1990).

111. According to Minkoff, *supra* note 6, at 947, "[t]here is no such thing as ideal treatment for chronic patients as a group. "Treatment of the chronically mentally ill involves "psychopharmacologic interventions to assist the ill person to acknowledge, bear, and accept the illness. Psychosocial interventions also help the individual to learn new coping strategies and rehabilitative skills to facilitate the process of adaptation." *Id.*

112. Goering, Wasylenki, Lancee & Freeman, *supra* note 32, at 672 (effective aftercare must include more programs with a rehabilitative/educational approach in outpatient community settings; the need for aftercare services in areas other than medical/therapeutic care is often underestimated by discharge planners); Hogarty, Goldberg & Schooler, *Drug and Sociosotherapy in the Aftercare of Schizophrenic*

Further, an individual ready for the daily decisions of community living should be involved as much as possible in the formulation of the plan and informed of available community services.¹¹³ Michigan provides a procedure whereby an individual in a program of alternative treatment or combined hospitalization and alternative treatment may submit a complaint to the provider of services regarding the quality and appropriateness of the treatment provided. A copy of the complaint and the provider's response is submitted to the court.¹¹⁴ Such measures have little practical effect, however, if alternative programs are nonexistent.

Nebraska law provides that, as part of the order of final disposition, the committing mental health board is authorized to designate "the director or other representative of the treatment program or facility to which the subject is assigned, to be responsible for supervising the preparation and implementation of an individualized treatment plan" and for recording and reporting the patient's progress to the board.¹¹⁵ Thus, an outpatient treatment center or psychiatrist apparently could be designated such responsibility. The treatment plan must contain

a statement of the nature of the specific mental and physical problems and needs of the subject, a statement of the least restrictive treatment conditions necessary to achieve the purposes of the board's order . . . and a description of intermediate and long-range treatment goals, with a projected timetable for their attainment.¹¹⁶

An outpatient treatment plan might also include a description of services and treatment to be administered, including possible side effects of medication and alternatives, if any; the settings in which treatment will be provided; identities of specific facilities and individuals who will provide treatment; and a statement of the criteria for unconditional release from involuntary treatment.¹¹⁷ Preparation of an af-

Patients, 31 ARCHIVES GEN. PSYCHIATRY 609, 609 (1974) ("appropriate sociotherapeutic intervention, administered in the context of chemotherapy, represents the ideal strategy for enhancing the adjustment and performance of schizophrenic patients in aftercare").

113. See KAN. STAT. ANN. § 59-2918a(a)(Supp. 1990)(in ordering outpatient treatment, the court shall consider all relevant factors, including the preferences of the patient); MICH. COMP. LAWS ANN. § 330.1469(1)(West 1980 & Supp. 1990)("The court shall inquire as to the desires of the individual regarding alternatives to hospitalization"); N.Y. MENTAL HYG. LAW § 29.15(f)(McKinney 1978 & Supp. 1988)(provides opportunity for patient to actively participate in the development of the outpatient treatment plan).

114. MICH. COMP. LAWS ANN. § 330.1483(2)(West 1980 & Supp. 1990).

115. NEB. REV. STAT. § 83-1044 (1987).

116. *Id.*

117. IMDL SUPPLEMENT *supra* note 16, Guideline H2.(b); MINN. STAT. ANN. § 253B.15 (West 1982 & Supp. 1990)("Each patient released on provisional discharge shall have an aftercare plan developed which specifies . . . the precise goals for the granting of a final discharge, . . . [and] the grounds upon which a provisional discharge may be revoked").

tercare plan for institutionalized mentally ill persons should be a routine practice for patients being released into the community, even if no legal sanctions are attached.¹¹⁸ In Virginia, the director of a state hospital may discharge recovered patients after the preparation of a predischarge plan formulated in cooperation with the community services board. The plan must (i) specify the community services required to meet the individual's needs for treatment, housing, nutrition, physical care, and safety; (ii) specify any income subsidies for which the individual is eligible; (iii) identify all local and state agencies which will be involved in providing treatment and support; and (iv) specify services which would be appropriate for the individual but which are currently unavailable.¹¹⁹ In addition to helping place individuals in appropriate programs as services become available, a specific finding in all treatment plans of the most appropriate treatment would enable decisionmakers to respond to the changing needs of the population of mentally ill persons in need of services in various regions.

2. Review

Periodic review of each patient's mental condition is necessary to determine whether continued commitment is justified and whether modification of the treatment plan or treatment setting is required. Regular examination of patients' needs encourages appropriate treatment and prompt discharge when involuntary treatment is no longer needed or the basis for the commitment no longer exists.

A majority of states have statutes requiring periodic examination of patients, with the frequency of examinations ranging from every thirty days to annually.¹²⁰ In addition, most states require periodic review of patient records, including the treatment plan.¹²¹ For exam-

118. See TEX. REV. CIV. STAT. ANN. art. 5547-67(a) (Vernon Supp. 1990) (discharged patients may refuse the services in a plan for aftercare); Bachrach, *supra* note 25; Meyerson & Herman, *What's New in Aftercare? A Review of Recent Literature*, 34 HOSP. & COMMUNITY PSYCHIATRY 333 (1983).

119. VA. CODE ANN. § 37.1-98A (1984 & Supp. 1990).

120. Weiner, *supra* note 5, at 268, lists 31 states plus the District of Columbia. Twelve of these states also permit review upon the petition of the patient or other person. See, e.g., ARIZ. REV. STAT. ANN. § 36-511.B (1986 & Supp. 1989) (reexaminations by appropriate professional persons each 90 days; full physical examination once per year); W. VA. CODE § 27-7-1 (1986) (chief medical officer shall continually review the case of each involuntary patient and "shall as frequently as practicable, in any event at least once every three months, cause a complete psychiatric examination of each patient" and discharge patients when the commitment criteria are no longer satisfied or treatment is no longer beneficial).

121. *Id.* See, e.g., ILL. ANN. STAT. ch. 91 1/2, para. 3-209 (Smith-Hurd 1987) (treatment plan shall be reviewed and updated as the patient's clinical condition warrants, but not less than every 30 days) and para. 3-814 :

Not more than 30 days after admission . . . the facility director shall file a

ple, Georgia requires review of outpatient treatment plans at "regular intervals" to determine the outpatient's progress toward the stated goals of the plan and to determine "whether the plan should be modified because of the patient's present condition."¹²² Nebraska requires the filing of a "progress report" to the mental health commitment board at least every ninety days for one year after the filing of the initial individualized treatment plans and every six months thereafter.¹²³

Although outpatients' conditions are monitored regularly during outpatient treatment and progress noted, a written determination of each outpatient's status should be completed at periodic intervals¹²⁴ and a copy submitted to the committing agency. In Michigan, the director of an alternative treatment program must review an outpatient's status as a person requiring treatment six months after an order of alternative treatment or of combined hospitalization and alternative treatment.¹²⁵ If an outpatient was hospitalized prior to beginning outpatient treatment, the director of the hospital may participate in the review. The results of the review are included within each patient's records and filed with the committing court within five days.¹²⁶ The results are also provided to the patient and his attorney, guardian, or relative.¹²⁷

Some commentators assert that the failure of states, such as Nebraska, to require regular examination of each patient is inconsistent with the principle of least restrictive treatment. "If a disabled person receives only an annual examination or record check, he could remain for many months in a setting or regimen that is not justified by his clinical condition."¹²⁸ This is a particular concern in Nebraska, which

current treatment plan with the court which includes an evaluation of the patient's progress and the extent to which he is benefiting from treatment. The court shall review the treatment plan. . . . The patient or an interested person on his behalf may request a hearing or the court on its own motion may order a hearing to review the treatment plan. If the court is satisfied that the patient is benefiting from treatment, it may continue the original order for the remainder of the admission period. If the court is not so satisfied, it may modify its original order or it may order the patient discharged.

122. GA. CODE ANN. § 88-512(a)(Harrison Supp. 1989). See also CAPLAN, *supra* note 8, at 121 (effective follow-up services must provide for "periodic review of each case to make sure that the patient continues to progress"); Stromberg & Stone, *supra* note 26, at 382 (model law).

123. NEB. REV. STAT. § 83-1045 (1987).

124. The frequency of examinations and reports will depend upon the period of allowable outpatient commitment. If outpatient commitment is allowed for six months plus extensions, for example, then reports might be required every ninety days.

125. MICH. COMP. LAWS ANN. § 330.1482(2)(West 1980 & Supp. 1990).

126. *Id.* at § 330.1483.

127. *Id.*

128. Weiner, *supra* note 5, at 268.

allows commitment for an indeterminate period.¹²⁹ In a study of the use of outpatient treatment as a less restrictive disposition for involuntarily committed patients, Wood and Swanson¹³⁰ noted a trend in Nebraska toward lengthy periods of commitment and a reluctance of clinicians to end commitment.

3. Right to Refuse Outpatient Treatment

The differences between legal and medical approaches to involuntary treatment are evident in issues pertaining to patients' rights to refuse prescribed treatment. Because psychotropic medication¹³¹ is the primary treatment provided to most psychiatric patients¹³²—particularly chronic patients with severe disorders¹³³—efforts to limit the discretion of mental health professionals to forcibly medicate¹³⁴ involuntarily committed patients have met with strong resistance.

Although most "right to refuse treatment" cases have involved the right to refuse antipsychotic medication during inpatient commitment,¹³⁵ similar issues arise in an outpatient setting. Courts have

129. Nebraska is one of only nine states which still permit indefinite commitments. Brakel, *supra* note 5, at 72.

130. Wood & Swanson, *supra* note 45.

131. "Psychotropic" medication includes antipsychotic drugs (major tranquilizers) for schizophrenia and related psychoses; antidepressant drugs for biochemical depression; lithium for treatment of manic-depressive (bipolar) disorder; and anti-anxiety drugs for situational and neurotic anxiety. Weiner, *Treatment Rights*, in *THE MENTALLY DISABLED AND THE LAW*, *supra* note 5, at 328.

132. *Id.* at 341.

133. Carpenter, McGlashan & Strauss, *The Treatment of Acute Schizophrenia Without Drugs: An Investigation of Some Current Assumptions*, 134 AM. J. PSYCHIATRY 14, 14 (1977) ("the treatment of schizophrenia has become so extensively drug oriented that a significant impediment has arisen to the exploration of alternative therapeutic approaches"); Gardos & Cole, *Maintenance Antipsychotic Therapy: Is the Cure Worse than the Disease?*, 133 AM. J. PSYCHIATRY 32 (1976); Kane, *Treatment of Schizophrenia*, 13 SCHIZOPHRENIA BULL. 133, 134 (1987) ("Antipsychotic drugs remain the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness").

134. Forcible medication may include forced medication by injection and also the threat of forced medication upon refusal to voluntarily take medication orally. *Rogers v. Okins*, 478 F. Supp. 1342, 1361 (D. Mass. 1979).

135. *See Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985) (absent an emergency, forcible medication with antipsychotic drugs violates inmate's due process rights); *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983) (due process requires an opportunity for hearing and review of a decision to administer antipsychotic medication but hearing need not be judicial); *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981) (enforced administration of antipsychotic drugs implicates fourteenth amendment right to be free from unjustified intrusions on personal security), *vacated and remanded in light of Youngberg v. Romeo*, 457 U.S. 307 (1982); *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980) (fourteenth amendment due process rights of privacy, bodily integrity and personal security), *vacated and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982); *Knecht v. Gillman*, 488 F.2d 1136, 1139 (8th Cir. 1973) (eighth amendment prohibition

often recognized a qualified right of a competent mentally ill patient to refuse medication absent an emergency.¹³⁶ Although the definition of "emergency" varies,¹³⁷ as well as specification of the decision-

against cruel and unusual punishment); *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973)(first amendment right of freedom from interference with thought processes); *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971)(right of a Christian Scientist to refuse medication found in first amendment guarantee of freedom of religion), *cert. denied*, 404 U.S. 985 (1971). *See also* *United States v. Bryant*, 670 F. Supp. 840 (D. Minn. 1987)(convicted federal prisoner has protected liberty interest in avoiding the unwanted administration of antipsychotic medication, but court need only make certain that professional judgment was exercised). *Cf. Youngberg v. Romeo*, 457 U.S. 307 (1982)(professional judgment standard).

136. *See* *Walters v. Western State Hosp.*, 864 F.2d 695 (10th Cir. 1988)(constitutional right to refuse psychotropic drugs "clearly established"). *Cf. Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982)(government officials performing discretionary functions generally are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights). *But see* *Lappe v. Loeffelholz*, 815 F.2d 1173 (8th Cir. 1987)(whether a prison inmate who was conditionally released from a security medical facility was entitled to a hearing before being forcibly medicated when he refused treatment was not clearly established in 1983).

However, the qualified right to refuse treatment has been eroded by some federal courts' interpretation of the deference to professional judgment sanctioned by the United States Supreme Court in *Youngberg v. Romeo*, 457 U.S. 307 (1982). *See, e.g., United States v. Charters*, 863 F.2d 302, 313 (4th Cir. 1988)(en banc)(under professional judgment standard, question is not whether the decision was the medically correct or most appropriate one; it is only whether the decision was made by an appropriate professional in the exercise of professional judgment, i.e., not arbitrarily. Due process is denied only if the decision was reached by a substantial departure from accepted professional judgment, practice, or standards); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983)(on remand).

Nonetheless, state courts are free to interpret state constitutions more broadly. *See, e.g., State ex rel Jones v. Gerhardtstein*, 141 Wis. 2d 710, 416 N.W.2d 883 (1987)(statutes which permit competent involuntarily committed individuals to be forcibly administered psychotropic drugs but require a finding of probable cause to believe precommitment detainees are incompetent before medication may be administered violate equal protection clauses of federal and state constitutions); *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337 (N.Y. 1986)(due process clause of New York Constitution affords involuntarily committed mental patients fundamental right to refuse antipsychotic medication, but right is not absolute); *People v. Medina*, 705 P.2d 961 (Colo. 1985)(competent and incompetent mentally ill persons have qualified right to refuse treatment that poses a significant risk to their physical well-being under common law and Colorado's statutory commitment scheme); *Rogers v. Commissioner of the Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983)(mental patient does not lose right to make treatment decisions until adjudicated incompetent).

137. *See* *Rogers v. Okin*, 634 F.2d 650, 656 (1st Cir. 1980)("the need to prevent violence in a particular situation outweighs the possibility of harm" from the medication); *Guardianship of Roe*, 421 N.E.2d 40, 42 (Mass. 1981)("an unforeseen combination of circumstances or the resulting state that calls for immediate action")(quoting WEBSTER'S THIRD NEW INT'L DICTIONARY 741 (1961); *Rogers v. Okin*, 478 F. Supp. 1342, 1365 (D. Mass. 1979)("a situation in which failure to [medicate] would result in a substantial likelihood of physical harm to that patient, other patients, or to staff members of the institution"); *Rennie v. Klein*, 462 F. Supp. 1131, 1154

maker who may override a refusal of medication,¹³⁸ a mentally disabled person is generally considered competent unless and until he is declared legally incompetent in a separate proceeding.¹³⁹

Unfortunately, patients are still often treated as clinically incompetent in institutional settings,¹⁴⁰ even though many patients may be capable of rationally participating in treatment decisions.¹⁴¹ The percentage of competent patients should be especially high for the patients who are stabilized or in remission and likely to be placed on outpatient commitment. Although some commentators assume the right to refuse treatment is necessarily sacrificed during outpatient commitment,¹⁴² this proposition is not self-evident. Arguably, if a patient will unequivocally refuse outpatient treatment, he is not a suitable candidate for outpatient commitment.¹⁴³ However, even

(D.N.J. 1978) ("a sudden, significant change in the [patient's] condition which creates danger to the patient himself or to others in the hospital").

138. See *Rogers v. Commissioner of the Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983)(courts); *Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983) ("medical authorities' professional judgment").
139. Weiner, *Treatment Rights*, in *THE MENTALLY DISABLED AND THE LAW*, *supra* note 5, at 341. See, e.g., *State ex rel. Jones v. Gerhardstein*, 135 Wis. 2d 161, 178, 400 N.W.2d 1, 8 (Wis. Ct. App. 1986)(incompetency not inferred from status of involuntary commitment); NEB. REV. STAT. § 1066(1)(1987)(persons in custody or receiving involuntary treatment have the right to be considered legally competent for all purposes unless they have been declared legally incompetent; mental health boards do not have power to declare an individual incompetent).
140. Weiner, *Treatment Rights*, in *THE MENTALLY DISABLED AND THE LAW*, *supra* note 5, at 341, 348. See Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 279 (1977) ("In psychiatry the entire edifice of involuntary treatment is erected on the supposed incompetence of some people to voluntarily seek and consent to needed treatment").
141. For example, in *Davis v. Hubbard*, 506 F. Supp. 915, 927 n.8 (N.D. Ohio 1980), the court found that 85% of the patients at Lima State Hospital were capable of rationally deciding whether to consent to the use of psychotropic drugs, and noted that few of the other 15% had been found incapable by a neutral party or tribunal. See also *Rogers v. Okin*, 478 F. Supp. 1342, 1361 (D. Mass. 1979) ("The weight of evidence persuades this court that, although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that may reasonably be expected from receiving psychotropic medication").
142. Mulvey, Geller & Roth, *supra* note 34, at 576-77 ("By definition, a person cannot refuse treatment while being involuntarily committed on an outpatient basis").
143. See e.g., ARIZ. REV. STAT. ANN. § 36-540.C(1)(c)(Supp. 1989)(outpatient or combined inpatient and outpatient treatment may be ordered only if the court finds that the patient will follow a prescribed outpatient treatment plan). Although a patient who is likely to comply with outpatient treatment arguably does not need involuntary commitment, some patients are more likely to comply if they are obligated to do so under a court order. Cf. TENN. CODE ANN. § 33-6-20(1)(C)-(D)(1984 & Supp. 1989)(patients may be discharged to outpatient treatment if "the patient is likely to participate in outpatient treatment with a legal obligation to do so; and the patient is not likely to participate in outpatient treatment unless legally obligated to do so").

incompetent noninstitutionalized patients may be entitled to a judicial determination of substituted judgment in which "the determination is *not* what is medically in the ward's best interests. . . . The determination [is] what the incompetent individual would do if competent. . . ." ¹⁴⁴

In *Guardianship of Roe*,¹⁴⁵ a mentally ill and incompetent ward was living at home following institutionalization at a state hospital. The ward's father had been appointed permanent guardian and was granted the authority to consent to the forcible administration of antipsychotic medication by a probate judge. On appeal, the Supreme Judicial Court of Massachusetts held that, "where no emergency exists, antipsychotic medication may be forcibly administered to a noninstitutionalized individual only in accordance with a court order."¹⁴⁶ A judge may order forcible medication when: 1) a judicial substituted judgment indicates the incompetent individual would accept antipsychotic drugs if he were competent; or 2) a state interest of sufficient magnitude exists to override the individual's right to refuse. If the state interest is the prevention of violence by noninstitutionalized mentally ill individuals, "the State is entitled to force the individual to choose, by way of substituted judgment, either involuntary commitment or medication with antipsychotic drugs."¹⁴⁷

However, individuals placed on outpatient commitment are already involuntarily committed; their choice would be between hospitalization and forcible medication. Massachusetts makes no statutory provision for outpatient commitment, though,¹⁴⁸ and other language in the opinion suggests that "involuntary commitment" is, in this context, being used synonymously with inpatient hospitalization.¹⁴⁹

Some outpatient statutes, in effect, abrogate the right to refuse treatment on the basis of past histories and anticipated future need.¹⁵⁰

144. *Guardianship of Roe*, 421 N.E.2d 40, 52 (Mass. 1981)(emphasis in original).

145. 421 N.E.2d 40 (Mass. 1981).

146. *Id.* at 61.

147. *Id.*

148. Geller, *supra* note 11, at 1262.

149. See *Guardianship of Roe*, 421 N.E.2d 40, 58 (Mass. 1981):

If an incompetent has enjoyed close family relationships and subsequently is forced to choose between two treatments, one of which will allow him to live at home with his family and the other of which will require the relative isolation of an institution, then the judge must weigh in his determination the affection and assistance offered by the incompetent's family.

But cf. IMDL SUPPLEMENT, *supra* note 16, Guideline G.2 ("Involuntary civil commitment is not necessarily synonymous with institutionalization. Compulsory hospitalization should be considered along with other available dispositional alternatives, including commitment to outpatient mental health facilities").

150. Bursten, *supra* note 23, at 1256 (Tennessee law).

L.B. 723, 92d Leg., 2d Sess. (1990) proposes to amend NEB. REV. STAT. § 83-1062 (1987), which permits "[a]ny qualified mental health professional, upon being au-

Other states permit psychopharmacological treatment following judicial or administrative review of the necessity for biological treatment based on a second medical opinion.¹⁵¹ In Wisconsin, an individual conditionally transferred to outpatient treatment may be taken into custody upon noncompliance with his treatment plan and prescribed medication "may be administered voluntarily or against the will of the individual. . . ."¹⁵² In Georgia, a noncomplying outpatient may be given any "emergency or other medical treatment."¹⁵³ If forcible medication is permitted during outpatient treatment, with fewer patient safeguards than are required for inpatient treatment and the possibility of blood checks to monitor compliance,¹⁵⁴ outpatient commitment loses much of its attractiveness as a less restrictive alternative to inpatient hospitalization.¹⁵⁵

thorized by the director of the mental health center or government, private, or state hospital having custody of the subject," to provide "appropriate medical treatment" for a subject against whom a certificate or petition has been filed, by adding the following language:

The subject may be physically required to take prescribed medication against his or her will, if such treatment is essential in the judgment of the mental health professional in charge of such treatment to prevent the subject from causing injury to himself, herself, or others or which will substantially improve his or her mental illness. This section specifically authorizes injection of medication against the wishes of the subject if ordered by a mental health professional in charge of such treatment.

Cf. NEB. REV. STAT. § 83-1066(3)(1987)(subjects "in custody or receiving treatment" have the right to "refuse treatment, except such treatment as is essential in the judgment of the mental health professional in charge of such treatment to prevent the patient from causing injury to himself or others or which will substantially improve his or her mental illness"). When read in conjunction with proposed § 83-1002, sec. 4 (*see infra* note 202 and accompanying text), LB 723 appears intended to permit forcible medication of noncomplying outpatients.

151. *E.g.*, KAN. STAT. ANN. § 59-2927a(b)(1983 & Supp. 1990)(objections to prescribed medication must be submitted to administrative review). In Nebraska, persons receiving involuntary treatment have the right to refuse treatment, "except such treatment as is essential in the judgment of the medical health professional in charge of such treatment to prevent the patient from causing injury to himself or others or which will substantially improve his or her mental illness." NEB. REV. STAT. § 83-1066(3)(1987).
152. WIS. STAT. ANN. § 51.20(13)(dm)(West 1987 & Supp. 1989). *Cf. id.* at § 51.61(g) ("Following a final commitment order, the subject individual does not have the right to refuse medication and treatment except as provided by this section"). *But see* State *ex rel.* Jones v. Gerhardstein, 135 Wis. 2d 161, 400 N.W.2d 1 (Wis. Ct. App. 1986)(involuntarily committed patients denied equal protection because statutes allow them to be forcibly medicated but do not permit forcible administration of drugs to voluntary psychiatric patients; state's interest in cost-efficient treatment not sufficient to justify unequal treatment of involuntarily committed).
153. GA. CODE ANN. § 37-3-82(b)(Harrison Supp. 1989).
154. *See* Geller, *supra* note 11; Mulvey, Geller, & Roth, *supra* note 34, at 576 ("the most efficient and valid way to monitor compliance with a chemically based treatment program is to use methods such as regular depot injections or blood tests").
155. *Compare* Miller & Fiddleman, *supra* note 23, at 149 ("Outpatient commitment

A number of empirical questions deserve analysis before outpatients are denied a qualified right to refuse medication. How many patients refuse treatment and how many simply fail to comply? What are the reasons for their noncompliance? How often does an emergency situation arise in which a patient's refusal may be overridden? How many patients are declared incompetent to make rational and informed treatment decisions?

A variety of implications may, of course, flow from the answers to such questions. If patients fail to follow prescribed treatment because they deny their illness, then perhaps a legal decree would encourage them to comply without requiring them to admit their illness (which is not entirely desirable but may be a step in the right direction).¹⁵⁶ If they refuse because of religious convictions, then perhaps their decision requires deference.¹⁵⁷ If they refuse because they have been prescribed psychotic medication before and have experienced side effects,¹⁵⁸ then perhaps a competent individual should be allowed to

provides an alternative that is actually more liberal for patients than either release or extended hospitalizations, but that remains unacceptable to many civil libertarian attorneys and judges") with *Guardianship of Roe*, 421 N.E.2d 40, 52 (Mass. 1981) ("few legitimate medical procedures . . . are more intrusive than the forcible injection of antipsychotic medication").

156. See Frances & Weiden, *supra* note 37, at 1159; Geller, *supra* note 11, at 1262; Schwartz, *A Revised Checklist to Obtain Consent to Treatment with Medication*, 31 HOSP. & COMMUNITY PSYCHIATRY 765, 766 (1980):

In the denial stage, the patient's capacity to give informed consent is not present or is very limited; he is still incompetent to evaluate his illness, although he may appear competent . . . in other respects. At this stage it may be destructive to confront the patient with facts about his illness and details of treatment or to insist on informed consent. This step may . . . impede his progress toward eventual acceptance of his illness and the treatment for it.

157. See *Winters v. Miller*, 446 F.2d 65 (2d Cir. 1971) (forced medication of involuntarily hospitalized mentally ill Christian Scientist violated right to freedom of religion); *In re Boyd*, 403 A.2d 744 (D.C. 1979) (mentally ill person who was adjudicated incompetent but had previously rejected use of medication on religious grounds was entitled to substituted judgment).
158. See *State ex rel. Jones v. Gerhardstein*, 135 Wis. 2d 161, 170, 400 N.W.2d 1, 9 (Wis. Ct. App. 1986) ("In certain cases it is possible that an involuntarily committed individual may retain the competency to gauge the advantages and disadvantages of psychotropic drugs. This is particularly true where the individual concerned has suffered, or witnessed, adverse reactions to such drugs in the past"). The most common side effects of antipsychotic medications are muscular effects which disappear when the drug is terminated: dystonic reactions (muscle spasms, irregular flexing, writhing or grimacing movements; protrusion of the tongue); akathisia (inability to stay still, restlessness, agitation) and Parkinsonisms (mask-like face, drooling, muscle stiffness and rigidity, shuffling gait, tremors). Plotkin, *Limiting the Therapeutic Orgy: Patients' Right to Refuse Treatment*, 72 NW. U. L. REV. 461, 475 (1977). Non-muscular effects include "drowsiness, weakness, weight gain, dizziness, fainting, low blood pressure, dry mouth, blurred vision, loss of sexual desire, frigidity, apathy, depression, constipation, diarrhea, and changes in the blood." *Id.* at 475-76. Tardive dyskinesia is the most serious, and long-term,

choose the course which she considers less intrusive: hospitalization without medication or community treatment with medication and side effects.¹⁵⁹ For a patient who simply misses appointments or does not consistently or appropriately take medication but does not refuse to do so, greater involvement and outreach efforts of community mental health professionals in monitoring compliance may be what is needed.

Another possibility is that patients who are accustomed to community life in a deteriorated state will achieve a capacity for insight which will encourage continued voluntary compliance after a threshold of time in successful community treatment is reached.¹⁶⁰ If this were the case, involuntary medication might be justified for a limited period of time to allow these individuals to reach the threshold. The possibility also exists that few outpatients would refuse medication,¹⁶¹ and giving committed outpatients a choice may enhance the benefits of treatment and give them a sense of greater control over their lives and treatment.¹⁶²

effect of antipsychotic drugs. Tardive dyskinesia causes convulsive muscle movements and may interfere with speech, eating, dexterity, and respiration. G. BURROWS, T. NORMAN & B. DAVIES, *DRUGS IN PSYCHIATRY: ANTIPSYCHOTICS* 186 (1985). Currently, no effective treatment for tardive dyskinesia is available, *id.* at 186, 199, 205, and its prevalence appears to be increasing. *Id.* at 188.

159. See *Guardianship of Roe*, 421 N.E.2d 40, 51 (Mass. 1981):

If the judge finds that there is a State interest sufficient to override the [incompetent] ward's choice to refuse treatment, but finds that the State interest can be satisfied by means other than forced medication, we then require . . . that the ward be afforded an extended substituted judgment determination in order to choose from among all acceptable and available means of satisfying the State interest.

See also *id.* at 58 ("Clearly any competent patient choosing whether to accept such treatment would consider the severity of these side effects, the probability that they would occur, and the circumstances in which they would be endured"); *Rogers v. Okin*, 478 F. Supp. 1342, 1361 (D. Mass. 1979) ("patients who have experienced such medication . . . have some basis for assessing comparative advantages and disadvantages"); Bachrach, *supra* note 7, at 99 ("What is restrictive for one patient may not necessarily be so for another"). Cf. *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984) ("less restrictive alternatives, such as segregation or the use of less controversial drugs like tranquilizers or sedatives, should be ruled out before resorting to antipsychotic drugs").

160. See Mulvey, Geller, & Roth, *supra* note 34, at 578-79; Geller, *supra* note 11, at 1262-63.
161. See *Rogers v. Okin*, 478 F. Supp. 1342, 1369 (D. Mass. 1979) (during litigation, only twelve of 1,000 patients actually refused medication); Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 AM. J. PSYCHIATRY 340 (1980) (most inpatient refusers subsequently accepted medication; permitting refusals did not seriously impair overall treatment and yielded some positive advantages); Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHIATRY & L. 179 (1980).
162. See *Rogers v. Okin*, 478 F. Supp. 1342, 1361 (D. Mass. 1979) ("a fundamental concept for treating the mentally ill is the establishment of a therapeutic alliance between psychiatrist and patient. Implicit in such an alliance is an understanding

Hiday and Scheid-Cook¹⁶³ studied a group of 69 outpatients committed in North Carolina between July 1984 and June 1985. Outcomes at six months were compared for chronically mentally ill patients with histories of medication refusal and dangerousness who were ordered to receive outpatient treatment and similar patients who were released or voluntarily hospitalized following civil commitment hearings. A target group with the characteristics of revolving-door patients was identified on the basis of four criteria: 1) severe mental illness, generally including patients with diagnoses of schizophrenia, paranoia, affective disorder, or other psychotic disorders; 2) one or more previous hospitalizations; 3) one or more dangerous actions, indicated by incidents of assaults, threats, or unintentional harm to self or other, or attacks on property; and 4) recent medication noncompliance.

The authors found that a majority of the target group (52.8%)¹⁶⁴ had refused medication at least once during the six-month period. Patients committed to outpatient treatment were less likely to refuse medication than patients who had been released, but were no more likely to refuse than were the patients who had been involuntarily hospitalized. Patients who were either released or committed to outpatient treatment were more likely than hospitalized patients to be noncompliant in actions such as keeping appointments or attending prescribed programs. Such results are not surprising; given the structured setting of most institutions, inpatients generally do not have the option of forgetting appointments or choosing not to attend. Further, only 31 of the 69 patients who were committed to outpatient treatment actually began outpatient treatment. Patients who began outpatient treatment had lower rates of medication refusal and other forms of noncompliance than committed outpatients;¹⁶⁵ 70.3% of committed

and acceptance by the patient of a prescribed treatment program"); Rennie v. Klein, 462 F. Supp. 1131, 1141 (D. N.J. 1978):

[A] trusting relationship or therapeutic alliance between psychiatrist and patient is essential for a drug regimen to succeed. . . . [P]sychotropic drugs are less efficacious in a hostile or negative environment. . . . [E]ven if the best drug is prescribed, if the patient is unwilling to accept it, the positive effects are greatly lessened, especially in terms of long range benefits.

(citations omitted); Schwartz, *supra* note 156, at 267 ("Chronic patients and those requiring long-term maintenance with psychotropics should be asked for consent repeatedly to ensure a valid informed consent. In addition to reviewing side-effects and gains, seeking consent periodically is an occasion for patient and doctor to renew their therapeutic alliance"). But see Perr, *Refusing Treatment—Who Shall Decide?*, 10 BULL. AM. ACAD. PSYCHIATRY & L. 233, 243 (1982).

163. Hiday & Scheid-Cook, *A Follow-Up of Chronic Patients Committed to Outpatient Treatment*, 40 HOSP. & COMMUNITY PSYCHIATRY 52 (1989); Hiday & Scheid-Cook, *supra* note 23.

164. Hiday & Scheid-Cook, *supra* note 23, at 225, Table 3.

165. Hiday & Scheid-Cook, *supra* note 163, at 57.

outpatients who received outpatient treatment did not refuse medication even once.¹⁶⁶

The effectiveness of medication in the treatment of the chronically mentally ill may vary with individual patients and, in some cases, may be more harmful than beneficial.¹⁶⁷ Until more information is available regarding noncompliance and how well the goals of outpatient commitment are achieved in practice, we should defer to the right of a competent outpatient to refuse medication in the absence of an emergency.¹⁶⁸

If a committed outpatient faces an emergency situation, procedures

166. Hiday & Scheid-Cook, *supra* note 23, at 225-26.

167. See Anthony, Cohen & Vitalo, *The Measurement of Rehabilitation Outcome*, 4 SCHIZOPHRENIA BULL. 365, 369 (1978) ("The serious and often irreversible complications of prolonged maintenance medication can interfere with rehabilitation programs. . . . While drug therapy can often support the initial rehabilitation intervention, long-term maintenance medication may actually hamper rehabilitation programming"); Carpenter, McGlashan & Strauss, *supra* note 133, at 14 (failing to use neuroleptics during an acute psychotic episode does not necessarily result in a disadvantageous course and outcome, and it may have some advantages"), and at 19 ("antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of their illness"); Franklin, Kittredge & Thrasher, *A Survey of Factors Related to Mental Hospital Readmissions*, 26 HOSP. & COMMUNITY PSYCHIATRY 749, 751 (no significant differences found between discharged state mental hospital patients who were readmitted and those not readmitted in medications prescribed, use of medications, lengths of prescription, dosages and current use of medication); Gardos & Cole, *supra* note 133, at 35-36 (as many as 50% of outpatient schizophrenic patients might not be worse off if their medications were withdrawn; some relapses after antipsychotic withdrawal are attributable to withdrawal emergent dyskinesia rather than to psychotic decompensation; because of serious complications of prolonged antipsychotic therapy, every chronic schizophrenic outpatient maintained on antipsychotic medication should have the benefit of an adequate trial without drugs). But see Hogarty, Goldberg, Schooler & Ulrich, *Drug and Sociotherapy in the Aftercare of Schizophrenic Patients*, 31 ARCHIVES GEN. PSYCHIATRY 603 (1974) (relapse rate for placebo group of discharged schizophrenic patients nearly twice as high as a comparable group of patients treated with drugs). See also Davis, Gosenfeld & Tsai, *Maintenance Antipsychotic Drugs Do Prevent Relapse: A Reply to Tobias and MacDonald*, 83 PSYCHOLOGICAL BULL. 431 (1976); Hogarty, *Treatment and Course of Schizophrenia*, 3 SCHIZOPHRENIA BULL. 587, 594 (1977) ("the discontinuation of any treatment, be it chemotherapeutic, social, psychological, or behavioral, results in a reversal of initial treatment-related gains"); MacDonald & Tobias, *Withdrawal Causes Relapse? Our Response*, 83 PSYCHOLOGICAL BULL. 448 (1976); Tobias & MacDonald, *Withdrawal of Maintenance Drugs with Long-Term Hospitalized Mental Patients: A Critical Review*, 81 PSYCHOLOGICAL BULL. 107 (1974).

168. See ARIZ. REV. STAT. ANN. § 36-512 (1986) (A person undergoing evaluation or treatment has a right to refuse any and all medical treatment unless ordered by the court, except when, in the written opinion of the attending physician, a true medical emergency exists); Morse, *supra* note 20, at 93 ("as long as a person is capable of expressing a preference about hospitalization and treatment, the state should not be able to substitute its judgment for that preference").

for emergency treatment should be instituted.¹⁶⁹ For example, North Carolina's outpatient commitment law states, "In no case may the respondent be physically forced to take medication or forcibly detained for treatment unless he poses an immediate danger to himself or others. In such cases inpatient commitment proceedings shall be initiated."¹⁷⁰ Hawaii provides that no subject of an outpatient commitment order "shall be physically forced to take medication or forcibly detained for treatment. . . ."¹⁷¹ If the subject refuses or fails to comply after reasonable efforts are made by the outpatient treatment staff to obtain compliance, the treating psychiatrist may submit a petition for involuntary hospitalization, but the refusal of treatment may not be considered as evidence for meeting the criteria for involuntary hospitalization.

Hawaii and North Carolina both have a lower standard for outpatient commitment than is required for inpatient commitment.¹⁷² Thus, involuntary outpatients might not meet the statutory criteria for involuntary inpatient treatment—or forcible medication.¹⁷³ States with the same standard for involuntary inpatient or outpatient treatment should, at a minimum, grant the same qualified right to refuse medication to outpatients as is afforded inpatients.

III. ENFORCEMENT: REVOCATION OF OUTPATIENT COMMITMENT

A. Statutory Procedures

As noted in the previous section, outpatient treatment may be provided to mentally ill persons through either conditional release or outpatient commitment statutes. Enforcement of outpatient orders is considered essential for effectiveness.¹⁷⁴ Without adequate monitoring of compliance, outpatient treatment may, in practice, be no different from unconditional release or no treatment.

169. Most states have special statutory provisions for emergency detention of dangerous mentally ill persons. *See, e.g.*, NEB. REV. STAT. § 83-1020 (1987). Medical certification is most common, *see* Brakel, *supra* note 5, at 51, with 3-5 days the most common limits for length of emergency detention. *Id.* A variation of this procedure for persons committed to outpatient treatment would permit inpatient treatment for a limited period of time in an emergency. At the end of the allowable period, the individual would be released or, if inpatient treatment is deemed necessary, a hearing for transfer to a more restrictive setting or a petition for inpatient treatment could be initiated. *See infra* p. 70.

170. N.C. GEN. STAT. § 122C-273(a)(3)(1989).

171. HAW. REV. STAT. § 334-129(b)(1985).

172. *See infra* section IV.

173. *See* Guardianship of Roe, 421 N.E.2d 40, 60 (Mass. 1981)(same standard of proof necessary for both involuntary commitment and involuntary medication proceedings).

174. *See* IMDL SUPPLEMENT, *supra* note 16, at 10.

Failure or refusal of the outpatient to comply with prescribed treatment may have varying consequences under these provisions. Violation of a conditional release often results in automatic return to the releasing facility.¹⁷⁵ Conditional release statutes which involve judicial authority generally require that the court be notified of the conditions of release and the return of an outpatient to inpatient treatment.¹⁷⁶ Judicial review may be available, at the patient's request, following rehospitalization.¹⁷⁷ Texas requires an administrative hearing before a patient's furlough can be revoked.¹⁷⁸ In Montana, a petition for rehospitalization of a patient conditionally released from an inpatient mental health facility may be filed by the county attorney, the professional person in charge of the patient's case, or the patient's next of kin. The court may order revocation and hospitalization if, after a hearing, the court finds by clear and convincing evidence that "the conditionally released patient has violated a condition of the release, that the violation has caused a deterioration of the patient's mental condition, and that as a result of this deterioration the patient can no longer be appropriately served by outpatient care."¹⁷⁹

Oregon follows the same procedures for an outpatient who fails to adhere to the conditions of treatment under outpatient commitment, conditional release, or a trial visit. The court "may cause the [outpatient] to be brought before [the court] for a hearing to determine whether the person is or is not adhering to the terms and conditions of the placement."¹⁸⁰ The outpatient is accorded all rights with respect to notice, detention, hearing and counsel as at an initial commitment hearing.¹⁸¹ Similarly, in Washington, the grounds and procedures for revocation are the same for conditional release and hospitalization alternatives. The court must determine whether the outpatient adhered to the conditions of outpatient treatment or whether "substantial deterioration" in the person's functioning has occurred and whether the

175. See *supra* notes 73 and 74.

176. *E.g.*, ALASKA STAT. § 47.30.795(b),(c)(1984); ARIZ. REV. STAT. ANN. § 36-540.01.I (1986 & Supp. 1989); WASH. REV. CODE ANN. § 71.05.340(1)(a)(Cum. Supp. 1990); TEX. REV. CIV. STAT. ANN. art. 5547-69(e)(Vernon Supp. 1990).

177. See ARIZ. REV. STAT. ANN. § 36-540.01.J (1986 & Supp. 1989); MO. REV. STAT. § 632.385(5)(Supp. 1990) ("Upon a receipt of a notification returning the patient to the facility as an inpatient, the committing court shall, if necessary order the sheriff or other law enforcement official to apprehend and transport the patient to the facility. The committing court may, on its own motion and shall upon the respondent's motion, order a hearing to be held on the need for such change."); WIS. STAT. ANN. § 51.35(1)(e)(West 1987 & Supp. 1989).

178. TEX. REV. CIV. STAT. ANN. art. 5547-69(d)(Vernon Supp. 1990).

179. MONT. CODE ANN. § 53-21-197 (b)(1989).

180. OR. REV. STAT. § 426.275(2)(1989).

181. *Id.*

conditions should be modified or the patient returned to the facility.¹⁸²

Outpatient commitment statutes generally require judicial order or modification in order to hospitalize a noncomplying outpatient. However, the procedural safeguards vary widely. Arizona,¹⁸³ Michigan,¹⁸⁴ and North Dakota¹⁸⁵ allow the court to enter a new order requiring hospitalization without a hearing, based solely upon the record and other available information. If the person refuses to comply with the new order, the court may direct a peace officer to take the person into protective custody and transport him to the hospital.¹⁸⁶ Judicial review may be available upon rehospitization.¹⁸⁷

Some states, such as Illinois¹⁸⁸ and Oklahoma,¹⁸⁹ provide notice to the outpatient and allow an opportunity for the outpatient to respond prior to modification or revocation of the outpatient order. In Illinois, a court which revokes an outpatient treatment order may order a peace officer to take the patient into custody and transport him to the facility.¹⁹⁰ In South Carolina, the court may order inpatient treatment following a supplemental hearing.¹⁹¹ Vermont allows modification of the original order or entrance of a new order for hospitalization following a new hearing.¹⁹²

Other states provide a full and fair hearing but allow hospitalization of a noncomplying outpatient prior to the hearing. In Texas, the court may order temporary detention pending a modification hearing if the court finds probable cause to believe the outpatient meets the criteria for court-ordered treatment and that inpatient detention is necessary for evaluation of the appropriate setting for continued treatment.¹⁹³ North Dakota permits a peace officer, physician, or mental health professional who reasonably believes that an outpatient is not complying with an order for alternative treatment, or that the alternative treatment is not sufficient to prevent harm, to have the outpatient

182. WASH. REV. CODE ANN. § 71.05.340(b)(3)(Cum. Supp. 1990).

183. ARIZ. REV. STAT. ANN. § 36-540.E.4 (1986 & Supp. 1989).

184. MICH. COMP. LAWS ANN. § 330.1469(9)(West 1980 & Supp. 1990).

185. N.D. CENT. CODE § 25-03.1-21 (Supp. 1987).

186. ARIZ. REV. STAT. ANN. § 36-540.E.4 (1986 & Supp. 1989).

187. *Id.*

188. ILL. ANN. STAT. ch. 91 1/2, para. 3-812(b)(Smith-Hurd 1987).

189. OKLA. STAT. ANN. tit. 43A, § 5-405 (West Supp. 1990).

190. ILL. ANN. STAT. ch. 91 1/2, para. 3-812(c)(Smith-Hurd 1987).

191. S.C. CODE ANN. § 44-17-580 (Law. Co-op. 1985 & Supp. 1989).

192. VT. STAT. ANN. tit. 18, § 7618(b)(1),(2)(1987)(if it comes to the attention of the court either that the patient is not complying with an outpatient treatment order or that alternative treatment has not been adequate to meet the patient's treatment needs, the court may, after proper hearing: (1) modify its original order and direct the patient to undergo another program of alternative treatment for the remainder of the 90-day period of commitment; or (2) enter a new order directing that the patient be hospitalized for the remainder of the 90-day period).

193. TEX. REV. CIV. STAT. ANN. art. 5547-53(c)(Vernon Supp. 1990).

taken into custody and detained in a treatment facility if "considerations of time and safety do not allow intervention by a court."¹⁹⁴

Georgia distinguishes the situation in which the outpatient physician determines that hospitalization is necessary because of a change in the patient's condition from the situation in which an outpatient fails or refuses to comply with outpatient treatment. In the former situation, the physician may execute a certificate for emergency treatment.¹⁹⁵ In the case of a noncomplying outpatient, the outpatient physician may petition the court for an order authorizing a peace officer to deliver the outpatient to the outpatient treatment facility or the nearest emergency receiving facility.¹⁹⁶ Following examination, the outpatient may be given any emergency or other medical treatment and must be released within four hours (forty-eight hours for an emergency receiving facility) unless the physician concludes that, because of a change in the outpatient's condition, hospitalization is required—in which case an emergency certificate may be executed.¹⁹⁷

North Carolina and Hawaii require the outpatient physician or center to make "all reasonable effort" to solicit compliance.¹⁹⁸ In North Carolina, such efforts must be documented and reported to the court with a request for a supplemental hearing. If the court determines the outpatient failed or refused to comply, the court may order an examination to determine the necessity for continued outpatient commitment or for inpatient commitment,¹⁹⁹ reissue or change the outpatient commitment order, or discharge the outpatient and dismiss the case. If the outpatient fails to comply but does not clearly refuse treatment, after reasonable efforts to solicit compliance fail, the outpatient treatment physician or center may request the court to order a law enforcement officer to take the noncomplying outpatient into custody and transport him to the designated outpatient physician or center for examination.²⁰⁰ In Hawaii, after efforts to solicit compliance fail, the outpatient psychiatrist must notify the court and may submit a petition for involuntary hospitalization.²⁰¹

In Nebraska, Legislative Bill 723 proposes to amend *Neb. Rev. Stat.* § 83-1002 to include the following:

Sec. 4. Outpatient treatment ordered by a mental health board constitutes a continuing authorization for the sheriff, upon request of the treatment facility

194. N.D. CENT. CODE § 25-03.1-21 (Supp. 1987).

195. GA. CODE ANN. § 37-3-41 -82 (Harrison Supp. 1989).

196. *Id.* at § 37-3-82(b).

197. *Id.*

198. N.C. GEN. STAT. § 122C-273(a)(1)(1989); HAW. REV. STAT. § 334-129(c)(1985).

199. The court may order an examination only upon a finding of probable cause to believe the respondent is mentally ill and dangerous to himself or others. N.C. GEN. STAT. § 122C-274(c)(1)(1989).

200. *Id.* at § 122C-273(a)(2).

201. HAW. REV. STAT. § 334-129(c)(1985).

or a mental health professional, to transport a subject to the treatment facility or the mental health professional's office for the purpose of making efforts to obtain the subject's compliance with requirements of the outpatient treatment order. The subject shall not be detained at the facility or the mental health professional's office for more than three hours.²⁰²

In contrast to similar procedures in states such as Georgia, North Carolina, and Hawaii, Nebraska's proposed procedure would bypass the need for a court order to involuntarily transport an outpatient to the treatment center. Thus, the treating professional could directly order a peace officer to take an outpatient into custody. This procedure might not be objectionable in and of itself; however, this bill would also permit the noncomplying outpatient to be forcibly medicated at the sole discretion of the treating professional.²⁰³ This result is unacceptable, particularly if the commitment criteria are broadened to include not only currently mentally ill and dangerous persons, but also persons who are not currently dangerous but are considered "likely to suffer substantial mental or physical deterioration" without treatment.²⁰⁴

B. Constitutional Requirements

Although statutory provisions for the care and treatment of mentally disabled persons are the primary responsibility of the states, procedures for enforcement and revocation of outpatient commitment or conditional release must meet the minimum requirements of the United States Constitution. Constitutional protections for the mentally ill have been found within the Due Process Clause of the fourteenth amendment.²⁰⁵ The requirements of due process apply if the asserted interest being threatened by state action is within the scope of the liberty or property language of the fourteenth amendment.²⁰⁶ The initial determination of whether an individual is entitled to any procedural protection involves an examination of the extent to which the person will be "condemned to suffer grievous loss" by the allegedly arbitrary action of the state.²⁰⁷

The Supreme Court has characterized involuntary confinement for treatment of mental illness as a "massive curtailment of liberty."²⁰⁸

202. L.B. 723, 92d Leg., 2d Sess. (1990).

203. See *supra* note 150.

204. See *supra* note 19.

205. U.S. CONST. amend. XIV ("nor shall any state deprive any person of life, liberty, or property, without due process of law").

206. See *Goss v. Lopez*, 419 U.S. 565 (1975); *Board of Regents v. Roth*, 408 U.S. 564 (1972); *Morrissey v. Brewer*, 408 U.S. 471 (1972); *Goldberg v. Kelly*, 397 U.S. 254 (1970).

207. *Goldberg v. Kelly*, 397 U.S. 254, 263 (1970)(quoting *Anti-Fascist Refugee Comm. v. McGrath*, 341 U.S. 123, 168 (1951)(Frankfurter, J., concurring)).

208. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

As Chief Justice Burger stated in *O'Connor v. Donaldson*,²⁰⁹ "There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law."²¹⁰ Further, *Morrissey v. Brewer*²¹¹ and *Gagnon v. Scarpelli*²¹² grant persons such as parolees and probationers protection from deprivation of conditional liberty without due process, even though revocation is not a stage of criminal prosecution.

In *Meisel v. Kremmens*,²¹³ a federal district court in Pennsylvania examined the "conditional liberty" enjoyed by a person who is released on parole after commitment to a mental institution.²¹⁴ The judge concluded:

I cannot see how the "conditional liberty" of the paroled mental patient differs in any significant respect from the "conditional liberty" of the paroled criminal or the paroled drug dependent person. Accordingly, I hold that the former likewise falls within the scope of the Fourteenth Amendment and must be protected by the constitutional safeguards of due process.²¹⁵

The rationale of the *Meisel* decision was followed by another federal district court in *Lewis v. Donahue*.²¹⁶ The plaintiff in *Lewis* was released on outpatient status after being involuntarily committed to a state mental hospital in Oklahoma. Two and one half months later she was rehospitalized pursuant to Oklahoma statutes, which provided for the revocation of outpatient status by judicial order, issued summarily, upon *ex parte* application.²¹⁷ The court held that the patient had a constitutionally protected interest in her conditional liberty, and that the statutory scheme for rehospitalization denied the patient due process because revocation was permitted without notice or opportunity to be heard before rehospitalization. In reaching its conclusion, the court stated:

209. 422 U.S. 563 (1975)(Burger, C.J., concurring).

210. *Id.* at 580.

211. 408 U.S. 471 (1972)(the conditional liberty of a paroled criminal falls within the scope of the fourteenth amendment and is entitled to the protection of the Due Process Clause).

212. 411 U.S. 778 (1973)(probation revocation results in loss of liberty; probationer is entitled to a preliminary and a final revocation hearing).

213. 405 F. Supp. 1253 (E.D. Pa. 1975).

214. *Id.* at 1256.

215. *Id.*

216. 437 F. Supp. 112 (M.D. Okla. 1977).

217. The Oklahoma Mental Health Law, OKLA. STAT. tit. 43A, 73 § (6)(1979), provided in relevant part:

In the event authorization is necessary to accomplish the return to the hospital of the patient on convalescent leave, such authority is hereby vested in the county judge of the county where the patient is located. Law enforcement officers are authorized to detain and transport a patient on convalescent leave to the hospital pursuant to an order by the county judge.

The granting of out-patient standing did change plaintiff's situation—she ceased to be a person who was institutionalized and became a person permitted to enjoy a substantial degree of liberty. Conversely, revocation of leave effected an involuntary transfer from a relatively non-restrictive environment to a restrictive one, and a correlative deprivation of a measure of freedom. . . . [A]n out-patient's enjoyment of his liberty is conditioned only upon his not again becoming a danger to himself or others.

A leave may properly be indeterminate, or terminable upon the happening of certain conditions. But it cannot be denied that conditional, as well as absolute, rights fall "within the contemplation of the 'liberty or property' language of the Fourteenth Amendment."²¹⁸

Although the analogy to the liberty interest in parole of a convicted criminal cannot be extended too far,²¹⁹ most courts are likely to find that a mental patient conditionally released from hospitalization has a liberty interest in that status which cannot be terminated without due process.²²⁰ The critical inquiry, of course, concerns what process is due for an outpatient facing revocation.

In *Mathews v. Eldridge*,²²¹ the Supreme Court outlined three factors which must be considered in identifying the specific dictates of due process:

[F]irst, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substi-

218. *Lewis v. Donahue*, 437 F. Supp. 112, 114 (M.D. Okla. 1977)(citation omitted).

219. Some courts have emphasized the differences between the revocation of a mental patient's conditional release and that of a convict's parole or probation. See *Hooks v. Jaquith*, 318 So. 2d 860, 862 (Miss. 1975), in which the Mississippi Supreme Court rejected the claim by a mental health patient whose conditional release had been revoked that he was entitled to habeas corpus relief because termination without a hearing unlawfully deprived him of liberty. The court stressed that revocation of a patient's conditional release is a medical determination rather than a factual or adversarial decision. Because outpatient status involves continuing treatment, the dictates of due process were not deemed germane to a mental health patient who has previously been lawfully committed to hospitalization.

220. See *In re Mills*, 467 A.2d 971 (D.C. 1983)(outpatient has conditional liberty interest in continuing outpatient status unless hospital can prove hospitalization is the least restrictive alternative); *Ball v. Jones*, 43 A.D.2d 281, 284, 351 N.Y.S.2d 199, 203-04 (1974), *aff'd sub nom. Pannell v. Jones*, 36 N.Y.2d 339, 368 N.Y.S.2d 467, 329 N.E.2d 159 (1975)(summary revocation of aftercare status and return of drug-dependent outpatients to inpatient status inflicts as "grievous" a loss as does revocation of parole); *Government of the United States ex rel. Shaban v. Essen*, 386 F. Supp. 1042 (E.D.N.Y. 1974), *aff'd without opinion*, 516 F.2d 897 (2d Cir. 1975)(revocation of outpatient status of drug-dependent person is unconstitutional without written notice and an opportunity to be heard); *In re Bye*, 12 Cal. 3d 96, 102, 115 Cal. Rptr. 382, 386, 524 P.2d 854, 859 (1974), *cert. denied*, 420 U.S. 996 (1975)(the label of "civil" rather than "penal" "does not alter the applicability of due process protections to the outpatient's [narcotics addict's] conditional liberty interest").

221. 424 U.S. 319 (1976).

tute procedural requirements would entail.²²²

As the Supreme Court noted in *Morrissey v. Brewer*,²²³ due process is flexible and "calls for such procedural protections as the particular situation demands. . . . Its flexibility is in its scope once it has been determined that some process is due; it is a recognition that not all situations calling for procedural safeguards call for the same kind of procedure."²²⁴

In *Morrissey*, two convicts alleged they were denied due process because their paroles had been revoked without a hearing. The Supreme Court agreed, holding that due process requires a reasonably prompt informal inquiry conducted by an impartial hearing officer near the place of the alleged parole violation or arrest prior to revocation. The purpose of the hearing is to determine whether reasonable grounds exist to believe a parole violation has occurred. The parolee is entitled to speak in his own behalf, to present evidence and cross-examine adverse witnesses,²²⁵ and to be provided with an informal statement of reasons for a decision revoking parole as well as an indication of the evidence upon which the decisionmaker relied. At the revocation hearing—which must promptly follow the preliminary hearing—the parolee is entitled to:

(a) written notice of the claimed violations of parole; (b) disclosure . . . of evidence against him; (c) opportunity to be heard in person and to present witnesses and documentary evidence; (d) the right to confront and cross-examine adverse witnesses (unless the hearing officer specifically finds good cause for not allowing confrontation); (e) a "neutral and detached" hearing body such as a traditional parole board, members of which need not be judicial officers or lawyers; and (f) a written statement by the factfinders as to the evidence relied on and reasons for revoking parole.²²⁶

Some courts have concluded that a pre-revocation hearing is required for outpatients as well as parolees. In *Lewis v. Donahue*,²²⁷ the court granted the declaratory and injunctive relief the plaintiff sought under 42 U.S.C. § 1983. Although the court declined to prescribe specific procedures which must be provided as a matter of law,²²⁸ the court concluded that a statute which permits the revocation of outpa-

222. *Id.* at 334-35.

223. 408 U.S. 471 (1972).

224. *Id.* at 481.

225. "However, if the hearing officer determines that an informant would be subjected to risk of harm if his identity were disclosed, he need not be subjected to confrontation and cross-examination." *Id.* at 487.

226. *Id.* at 489.

227. 437 F. Supp. 112 (M.D. Okla. 1977).

228. Federal courts are generally reluctant to interfere in state mental health systems by outlining specific procedures required by due process. *See, e.g., C.R. v. Adams*, 649 F.2d 625 (8th Cir. 1981)(abstention proper, in part because of the unsettled state of Iowa law regarding whether an outpatient has a right, under Iowa law, to notice and a hearing before his status is revoked and he is returned to an institution for inpatient treatment).

tient leave without notice or an opportunity to be heard prior to reinstitutionalization does not comport with due process.

Several courts have applied *Morrissey* to the outpatient setting and, consequently, have required a pre-revocation hearing. Pennsylvania's statute provided for summary revocation of leaves of absence from state mental health facilities at the discretion of the director of the facility.²²⁹ In *Meisel v. Kremmens*,²³⁰ the plaintiff sought declaratory relief when his leave of absence was terminated based on information supplied by his father. The plaintiff was detained without an opportunity to challenge the factual and medical bases of the revocation. The federal district court concluded that the principles announced in *Morrissey* were controlling; thus, the statute was unconstitutional as violative of rights secured by the Due Process Clause.

Similarly, in *Ball v. Jones*,²³¹ all the procedural safeguards mandated by *Morrissey* were held applicable to the revocation of narcotics addicts' aftercare status. In *Pannell v. Jones*,²³² the New York Court of Appeals modified the lower court's order:

When an outpatient's conduct, or external factors, unequivocally suggest that reconfinement is medically necessary, only a limited hearing is required. The outpatient is entitled to be informed of the reasons for reconfinement, preferably in writing, . . . and must be given the right to respond. The hearing need only be a summary and informal appearance before an administrator

Where the outpatient's conduct, or external factors, are equivocal or have only a tangential relationship to the medical problems of the patient then both a preliminary and final hearing are required *before* reconfinement may be ordered. The procedures then are substantially the same as for parole revocation²³³

229. Section 419 of the Mental Health and Mental Retardation Act of 1966, PA. STAT. ANN. tit. 50, § 4419 (Purdon 1969) provided:

(a) the director of any facility, in his discretion, may allow a leave of absence to any person admitted or committed . . . for a period not exceeding one year, and upon such terms and conditions as he may prescribe consistent with regulations of the department and the director may renew or extend a leave of absence for an additional period or periods not exceeding one year for each such renewal or extension.

(b) Leaves of absence may be terminated by the director who may, if necessary, authorize the apprehension and return of the person [on leave] . . . by any sheriff, constable or police officer who shall apprehend and return such person.

(c) Whenever a leave of absence is granted or extended to a period of three years and such leave is not terminated by the director . . . , upon the expiration of such three year period, the person admitted or committed shall be deemed to be discharged.

Section 419 has since been repealed, except as applied to mentally retarded persons. See *id.* at Supp. 1988.

230. 405 F. Supp. 1253 (E.D. Pa. 1975).

231. 43 A.D.2d 281, 351 N.Y.S.2d 199 (1974).

232. 36 N.Y.2d 339, 368 N.Y.S.2d 467, 329 N.E.2d 159 (1975).

233. *Id.* at 343, 368 N.Y.S.2d at 471, 329 N.E.2d at 161-62 (emphasis added).

The court of appeals did not specify whether the limited hearing for "unequivocal" outpatients must occur prior to revocation, but that result seems likely in light of the order of the appellate division,²³⁴ the need to determine whether recommitment is medically necessary (*i.e.*, the court of appeals' test for whether a revocation hearing is also required), and the requirement of both a preliminary and final hearing *before* recommitment for "equivocal" outpatients.²³⁵

However, reliance upon the criminal analogy is limited for determining what process is due a mental patient whose conditional release is subject to revocation. The Supreme Court has recognized that significant differences between the criminal setting and the civil commitment setting necessitate different due process considerations.²³⁶ In *Addington v. Texas*,²³⁷ the Court found the "clear and convincing" standard appropriate for involuntary civil commitment proceedings. In rejecting the higher criminal standard of proof, Chief Justice Burger declared that "a civil commitment proceeding can in no sense be equated to a criminal prosecution."²³⁸ Three distinctions between the civil commitment and criminal settings were noted. First, in civil commitment proceedings, the state's power is exercised to provide care and treatment, whereas the state's power is exercised punitively in criminal convictions. Second, because of the continuing administrative review of a mental patient's condition,²³⁹ the risk of an erroneous civil commitment is less than the risk of an erroneous criminal conviction. Finally, the inquiry in criminal proceedings is addressed to specific, ascertainable facts, whereas commitment proceedings require interpretations of diagnoses and predictions of future behavior based on imprecise factors.²⁴⁰

A court may recognize a protectible "conditional liberty" interest

234. The appellate division, in applying *Morrissey*, required both an informal pre-revocation hearing and a revocation hearing. The court of appeals did not overturn the decision; thus, elimination of the requirement of a revocation hearing did not alter the requirement of an informal hearing.

235. Of course, the court's analysis may be flawed in that, if recommitment is not "medically necessary," a constitutional basis for hospitalization may be lacking. See discussion of *Birl v. Wallis*, *infra* text accompanying notes 279-90.

236. See *Parham v. J.R.*, 442 U.S. 584 (1979) (when parents seek to have their child committed, or the state attempts to commit a ward of the state in voluntary commitment proceedings, fewer procedural protections are required than in juvenile delinquency proceedings).

237. 441 U.S. 418 (1979).

238. *Id.* at 428.

239. See *supra* Section II.B.2.

240. The medical nature of civil commitment issues was also stressed in *Vitek v. Jones*, 445 U.S. 480 (1980) (procedural safeguards for transfer of prisoners to mental institutions). See also *Parham v. J.R.*, 442 U.S. 584, 609 (1979) ("the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real").

under the fourteenth amendment yet find the state's outpatient or conditional release statute constitutional. In *Dietrich v. Brooks*,²⁴¹ the Oregon Court of Appeals concluded the "profound differences of nature, degree and function" between parole and conditional release made different due process considerations appropriate.²⁴² Oregon statutes provided that only trial visits of less than ninety days could be terminated without a hearing.²⁴³ Parole, on the other hand, is discretionary and limited only by the expiration of the parolee's sentence. The court stressed that termination of conditional release is not an isolated event; rather, it is part of a sequence of events within a course of confinement and treatment.²⁴⁴ The court held that Oregon's overall statutory scheme of involuntary commitment afforded adequate procedural protections upon summary revocation of conditional release. By statute, revocation of trial visits of more than ninety days required an administrative hearing, including the right to counsel, within seven days of rehospitalization.²⁴⁵

The California Supreme Court concluded in *In re Bye*²⁴⁶ that "the entire panoply of procedures outlined in *Morrissey* as applicable to parole revocations is neither constitutionally mandated nor practically desirable" in summary revocations of an addict's outpatient status.²⁴⁷ Mr. Bye's outpatient status was revoked because his parole agent feared his imminent return to narcotics based on reports by neighbors that Bye was behaving irrationally. The court recognized that a prompt in-community hearing may, in appropriate cases, be helpful to an outpatient suspected of violating the conditions of his release, but concluded that, on balance, "due process does not require such a preliminary determination in those cases where the outpatient is apprehended for reasons relating to resumed narcotic use or for symptoms or actions indicating the imminent danger of return to narcotic use."²⁴⁸

The court's concern was not with the substantive soundness of the revocation decision, but rather in establishing procedures to insure the decision is based upon all relevant facts. The court reasoned that the medical nature of the revocation decision and the need for prompt return of an addict who is in remission outweigh the "legitimate" need

241. 27 Or. App. 821, 558 P.2d 357 (1976).

242. *Id.* at 825, 558 P.2d at 360.

243. OR. REV. STAT. § 426.290 (repealed 1985).

244. *Dietrich v. Brooks*, 27 Or. App. 821, 827, 558 P.2d 357, 360 (1976). The court's distinction is, however, a weak one; the court's statement is also applicable to parole.

245. *Id.* at 826, 558 P.2d at 359.

246. 12 Cal. 3d 96, 524 P.2d 854, 115 Cal. Rptr. 382 (1974), *cert. denied*, 420 U.S. 996 (1975).

247. *Id.* at 98, 524 P.2d at 856, 115 Cal. Rptr. at 384.

248. *Id.* at 106, 524 P.2d at 861, 115 Cal. Rptr. at 389.

to attack the accuracy of the complainant's perceptions and statements at a preliminary hearing.²⁴⁹ Thus, outpatients "who are taken into custody for purported violations of their outpatient status which do not indicate an imminent return to narcotics may nevertheless be accorded the same unitary revocation procedure."²⁵⁰ The court accorded great weight to the need for immediate return of a "defaulting" outpatient to the treatment facility.²⁵¹ As a result, the court rejected the reasoning of the *Ball* court, which considered a preliminary hearing necessary because of an anticipated time lag between arrest and eventual disposition. However, the *Bye* court did suggest that a different result might be warranted if the Narcotic Addict Evaluation Authority could not comply with the prompt return policy.

Further, the court concluded that upon the addict's return to the treatment facility, he must be provided with a written statement enumerating the charges against him, the evidence relied upon, and the names of the witnesses who offered evidence against him. The patient must also be informed in writing of the right to challenge the truth of the charges at a revocation hearing which must be held shortly after his return to the facility. At the formal hearing, the six *Morrissey* requirements apply, as well as the right to representation by counsel when deemed necessary.

The same reasoning was applied to mentally ill outpatients in *In re Anderson*.²⁵² The respondent had been released on outpatient status from the state mental hospital, where he had been admitted following his acquittal on an insanity plea. He was summarily returned ten months later on the initiative of local mental health personnel. The court noted that the habeas corpus relief provided by statute is an after-the-fact determination, whereas "[t]he fundamental mandate of the Fourteenth Amendment is that a person be afforded notice and an opportunity to be heard *prior* to deprivation of a significant liberty or property interest."²⁵³ Further, habeas corpus relief is not mandatory. However, the court concluded that the need for immediate recommitment and the medical nature of the decision render an in-community preliminary hearing inappropriate. As in *Bye*, the court found a unitary hearing is required as soon as reasonably possible following the patient's return to the hospital.

The Idaho Supreme Court also found a post-revocation hearing sufficient due process protection for outpatients in *In re True*.²⁵⁴ The district court had quashed the habeas writ of a conditionally released

249. *Id.* at 107, 524 P.2d at 861, 115 Cal. Rptr. at 389.

250. *Id.* at 109, 524 P.2d at 863, 115 Cal. Rptr. at 391.

251. *Id.* at 107, 524 P.2d at 862, 115 Cal. Rptr. at 390.

252. 73 Cal. App. 3d 38, 140 Cal. Rptr. 546 (1977).

253. *Id.* at 45, 140 Cal. Rptr. at 551 (citation omitted).

254. 103 Idaho 151, 645 P.2d 891 (1982).

outpatient who was summarily returned to the hospital. The Idaho Supreme Court balanced the outpatient's interest in insuring that the revocation is based on an accurate diagnosis and evaluation of the facts against the state's need to conduct its program of treatment with a minimum of judicial interference. The court concluded that, although mental patients are entitled to due process in revocation of conditional release, the important differences from the parole system "are such that the procedures outlined in *Morrissey* for parole revocation, both in terms of timing and formality, are inappropriate . . ." ²⁵⁵ The court reasoned that the governmental interest involved in a decision to rehospitalize a patient concerns the protection of society and/or the patient; thus, "timing becomes more critical" than in the parole setting. ²⁵⁶ The court also noted that deference must be given to decisions which are "peculiarly medical in nature and as such are less subject to objective inquiry than in the parole system." ²⁵⁷

The court determined that the statutory provisions enabling a mental patient to seek an after-the-fact determination of the propriety of an order of rehospitalization did not adequately protect the interests of a patient or assure meaningful review. Further, the provisions placed the burden on the patient to bring forth sufficient facts to justify relief from an order of rehospitalization. "It is the state, in cases where it seeks to deprive an individual of a protectible liberty or property interest, which must bring forth sufficient facts justifying its summary action." ²⁵⁸ However, because of the "great weight" ²⁵⁹ accorded the need for immediate rehospitalization, the court concluded the general rule that an individual be given a hearing before he is deprived of a protectible interest is inapplicable. "The situation present when a decision is made to revoke the conditional release status of the patient is extraordinary: the patient because of a suspected remission in his mental condition possibly poses a danger to others and/or to himself." ²⁶⁰

In order to guard against an erroneous decision that rehospitalization is warranted, the court outlined the minimal due process requirements:

- (1) prompt written notice to the patient of the reasons for and evidence relied on justifying rehospitalization as well as notice of the right to challenge the allegations and (2) a hearing before a neutral hearing body to be held as

255. *Id.* at 161, 645 P.2d at 901.

256. *Id.* at 162, 645 P.2d at 902. Of course, parole violations might also concern the protection of society; the court's concern seems to focus on the protection of the individual, whose "progress toward recovery . . . is seriously jeopardized by a remission which is left untreated." *Id.*

257. *Id.*

258. *Id.* at 160, 645 P.2d at 900 (citations omitted).

259. *Id.* at 162, 645 P.2d at 902.

260. *Id.*

soon as is reasonably possible following the patient's rehospitalization, at which time the patient is to be afforded the right to counsel, the right to present evidence and examine witnesses, and upon a decision sustaining the order of rehospitalization, the right to a written statement by the fact-finding body as to the reasons for revocation. . . .²⁶¹

However, Justice Bistline, concurring specially, applied the same due process balancing test of *Mathews v. Eldridge*²⁶² upon which the majority relied and found that the restrictions on liberty were beyond those necessary to achieve the statutory goals. He concluded that the private interest involved—the individual's liberty—is “of the first order,”²⁶³ with a correspondingly great harm resulting from an erroneous determination. Noting the imprecise nature of diagnoses of medical disorders, the “great risk” of an erroneous deprivation of liberty weighed heavily in favor of extensive procedural safeguards.²⁶⁴

Justice Bistline emphasized the fundamental precept of due process that, if possible, the proper procedures be accorded *prior* to deprivation of the protected interest. He noted that the required showing for recommitment is identical for the original commitment, which must be *preceded* by a hearing. In his view, the majority improperly placed the burden upon the patient to show that a pre-deprivation hearing is required. He considered a hearing in the first instance necessary to determine whether the facts asserted are true.

It would be wrong, and in many cases tragic, to assume that all reports of “relapses” are either accurate or necessarily justify immediate rehospitalization. As the court noted in *C.R. v. Adams, supra*, “[i]f the patient is refusing treatment, *which usually means missing appointments*, the treating psychologist informs the mental health referee, who has the authority to issue an order for the patient's return to the hospital.” The fact that a patient misses an appointment during out-patient treatment does not necessarily indicate a danger to the community or to the individual. On the other hand, the harm suffered by unnecessary reinstitutionalization cannot be cured by a post-deprivation hearing. The possibility of simple error in the factual basis for a reported relapse gives rise to the spectre of the conditionally released patient being plucked up by the state from his or her home or place of work, with no prior notice, and returned to an institution, even in those instances in which the patient has indeed in all respects followed the conditions of the release program. This cannot be tolerated.²⁶⁵

Further, according to Justice Bistline, the medical nature of the inquiry does not justify dispensing with the requirements of due process. “It is precisely ‘the subtleties and nuances of psychiatric diagnoses’ that justify the requirement of adversary hearings.”²⁶⁶

261. *Id.* at 163, 645 P.2d at 903.

262. 424 U.S. 319, 334-35 (1976).

263. *In re True*, 103 Idaho 151, 164, 645 P.2d 891, 904 (1982).

264. *Id.*

265. *Id.* at 165, 645 P.2d at 905. (Bistline, J., concurring)(emphasis added)(citations omitted).

266. *Id.* at 166, 645 P.2d at 906 (citing *Vitek v. Jones*, 445 U.S. 480 (1980)).

Consequently, Justice Bistline would have held that the Due Process Clauses of the United States and Idaho Constitutions require that conditionally released mental patients, except in emergency situations, receive procedural safeguards prior to reinstitutionalization, including (1) written notice; (2) an in-community hearing to determine whether recommitment is necessary; (3) an opportunity to present evidence and testimony and to cross-examine adverse witnesses; and (4) legal counsel.

In addition to applying constitutional standards to commitment and revocation procedures, judicial interpretation of state statutes is often necessary. Observing that the distinctions between parole or probation and outpatient therapy justify different procedural safeguards, the District of Columbia Court of Appeals concluded in *In Re Richardson*²⁶⁷ that a hearing prior to brief rehospitalization is not required by the District of Columbia Hospitalization of the Mentally Ill Act. However, the court determined the Act required more stringent safeguards than the order of the trial court provided.

Richardson involved three consolidated appeals from inpatient commitment orders. Mr. Cade and Mr. Richardson were admitted to St. Elizabeth Hospital as emergency patients. The Commission on Mental Health conducted hearings after the hospital instituted civil commitment proceedings. The Commission noted that Cade had been admitted on six previous occasions; his condition improved with medication, but he had failed to comply with his treatment program and had been without medication for several weeks. He was presently experiencing hallucinations and paranoid delusions. In Richardson's case, the Commission observed that he had recently signed himself out of the hospital against medical advice, and "eloped" from the institution numerous times in the past.²⁶⁸ The Commission noted that without medication and appropriate treatment Richardson's condition would deteriorate, but he had been hostile about taking his medication. The Commission concluded that the conditions of both men had been sufficiently stabilized to permit their return to the community, provided that each take his medication and abide by his treatment regimen.

The trial court entered final orders committing both men to outpatient treatment programs. Pursuant to the hospital's request, the court incorporated into both outpatient commitment orders a provision authorizing the hospital to return the patient summarily to the institution for no more than five days in the event his condition deteriorated or he failed to comply with therapy. The orders provided further that, beyond the five-day period, the hospital must either petition

267. 481 A.2d 473 (D.C. 1984).

268. *Id.* at 477.

the court for an indeterminate commitment or return the individual to the outpatient program. Cade and Richardson appealed from the final orders.

Mr. Ellerbee was also admitted to the hospital as an emergency patient. The Commission noted that he had been admitted on five previous occasions, and had failed in the past to take his medication or comply with outpatient therapy. The Commission recommended hospitalization until placement in a supervised residential facility could be arranged. The court issued the order of commitment, but refused to include a provision authorizing temporary return to inpatient care in the event of deterioration or noncompliance.

The court set out procedures for cases in which the hospital determines a patient is likely to injure himself or others as a result of mental illness unless immediately rehospitalized. The court required an affidavit to be filed with the court, setting forth sufficient information to justify the proposed temporary detention. The court would then determine within twenty-four hours whether the patient should be returned to the hospital for a period up to five days.²⁶⁹ If the hospital could not demonstrate the need for emergency rehospitalization, the patient would not be returned to inpatient care, even for a temporary period, until the court determined after a hearing that detention was justified. The hospital appealed from the order committing Ellerbee to outpatient treatment, asserting the trial court erred in requiring judicial review prior to temporary return to inpatient care.

The appellate court considered the narrow issue of whether a commitment order may authorize summary return to the hospital for a brief period of reevaluation and treatment in the event a patient's condition deteriorates or he fails to comply with the terms of the outpatient treatment plan. The court recognized that "[n]ot every instance of the outpatient's failure to take prescribed medication or attend therapy sessions justifies the conclusion that he is not cooperating with the treatment program."²⁷⁰ However, the court noted:

[W]ithout the steadying influence of medication and other features of the outpatient program, certain patients may become violent or return to the habits and misperceptions that led to their original commitment. . . . Therefore, the Hospital must be accorded some measure of flexibility in determining when a particular patient is in need of institutional care.²⁷¹

The court emphasized that a summary return provision should be included in a commitment order only when, in light of the patient's condition and medical history, such a provision appears warranted. Noting that each of the patients had been committed to outpatient

269. After five days, the hospital must either release the individual or move for a prompt adversary judicial hearing seeking revocation of outpatient status. *See id.* at 481.

270. *Id.* at 479 n.5.

271. *Id.* (citation omitted).

treatment programs in the past and had experienced difficulty in adjusting to life in the community or the requirements of the program, the court found ample support in the record for inclusion in the commitment order of provisions authorizing prompt reevaluations. Rehospitalization was viewed as part of the treatment process, rather than as an isolated event.

The court also recognized that "the Hospital staff, or those upon whose information they rely, may err in concluding that the outpatient has violated a condition of his release or has become increasingly disoriented."²⁷² In order to assure the trial court an opportunity to determine whether temporary rehospitalization is appropriate, the court concluded that the superintendent of the hospital must provide the court with an affidavit, reciting recent actions of the patient and reasons for his return, within twenty-four hours of the patient's return. The affidavit would enable the court to make an *ex parte* determination that the patient has failed to follow the outpatient treatment program or that his condition has deteriorated and temporary determination is justified. The court concluded these procedures adequately guard against the erroneous deprivation of the outpatient's conditional release and satisfy due process.²⁷³ However, the court found no need for a second civil commitment proceeding since "the sole question to be decided on a return is whether institutional care is now appropriate, not whether the patient is mentally ill and likely to injure himself or others."²⁷⁴

Similar procedures were adopted by the Minnesota Supreme Court in *In re Peterson*.²⁷⁵ When Ms. Peterson was conditionally released from hospitalization for a psychiatric disorder, she was required to continue prescribed medication and keep scheduled outpatient ap-

272. *Id.* at 480. The court further noted that "[t]he prospect of error is somewhat enhanced by the possibility that in certain instances, the friends or relatives of an outpatient may seek his return to the institution because they feel uncomfortable in his presence or are dissatisfied with the progress he is making. . . ." *Id.*

273. The hospital may detain a patient for a maximum of five days without a full judicial hearing. Thus, the possible length of wrongful deprivation of liberty would be minimal. The affidavit procedure outlined in *In re Richardson* was recently enforced in *In re Feenster*, 561 A.2d 997 (D.C. 1989). Four days after a committed outpatient requested voluntary admission to the hospital, the hospital filed a petition to revoke the outpatient commitment order. The notice of rehospitalization was not filed for another six days due to administrative error. The outpatient commitment was subsequently revoked, and indefinite hospitalization ordered.

The Court of Appeals of the District of Columbia concluded that the involuntary detention for ten days before the hospital submitted the affidavit violated the outpatient's rights under the Act; thus, the revocation of the outpatient commitment order was rendered invalid by the illegal detention.

274. *In re Richardson*, 481, A.2d 473, 481 n.8 (D.C. 1984). *But see In re Stokes*, 546 A.2d 356, 363 (D.C. 1988) ("New findings of mental illness and dangerousness must be made at the revocation hearing.").

275. 360 N.W.2d 333 (Minn. 1984).

pointments. Shortly following the plaintiff's provisional discharge, she was hospitalized after behaving "bizarrely."²⁷⁶ The court ordered revocation of the provisional discharge and the patient's return to the hospital without notice to her attorney. Minnesota statutes define procedures for revocations more than sixty days after discharge,²⁷⁷ but are inapplicable to revocations during the sixty-day period.²⁷⁸

The Minnesota Supreme Court concluded the statute did not vest the head of the treatment facility with absolute and final discretion to revoke a provisional discharge within the sixty-day period; the decision must be subject to some form of review. The court concluded that brief rehospitalization without a prior adversarial hearing is authorized when the head of the facility provides the court, within forty-eight hours of rehospitalization, with an affidavit reciting the recent actions of the patient and reasons for her return. The patient and her counsel must be provided with a copy of the affidavit. The patient may challenge the basis for the decision by filing an affidavit specifying her reasons for contesting. The court must then make the threshold determination of whether a genuine issue exists concerning the propriety of the revocation. Proceedings must be completed within five days of the rehospitalization. Because the plaintiff provided no evidence showing the information relied upon in support of her revocation was either false or misinterpreted, the court affirmed the trial court's order denying the plaintiff's motion to dismiss the revocation.

Alabama's revocation procedures were declared unconstitutional in *Birl v. Wallis*.²⁷⁹ Plaintiff Birl had been involuntarily committed to a state mental institution and then released on a "trial visit"²⁸⁰ after

276. *Id.* at 335.

277. Under MINN. STAT. ANN. § 253B.15(2)-(5) (West 1982 & Supp. 1990), the head of a facility is authorized to revoke a provisional discharge if:

(i) The patient has violated material conditions of the provisional discharge, and the violation creates the need to return the patient to the facility; or

(ii) There exists a serious likelihood that the safety of the patient or others will be jeopardized, in that either the patient's need[s] for food, clothing, shelter, or medical care are not being met, or will not be met in the near future, or the patient has attempted or threatened to seriously physically harm himself or others.

278. Minnesota statutes provided that "[d]uring the first 60 days of a provisional discharge, the head of the treatment facility, upon finding that either of the conditions set forth in subdivision 2 exists, may revoke the provisional discharge without being subject to the provisions of subdivisions 2 to 5." *Id.* § 253B.15(6).

279. 619 F. Supp. 481 (M.D. Ala. 1985).

280. Under the trial visit program, the patient was released with instructions to continue with previously prescribed medication and therapy. Arrangements were made for a community mental health center to provide continuity of care based on a treatment plan. Patients were informed in writing of the conditions of the trial visit prior to release. The goals of the trial visit program included helping the individual maintain stability, participate in follow-up treatment, and adjust to life in the community.

a successful "temporary visit" with his mother for fourteen days.²⁸¹ Alabama Department of Mental Health policy allowed the return of an individual within six months of release without a new commitment hearing. After six months without return, the individual was considered unconditionally discharged. Community mental health centers could recommend a patient's return to the hospital, but the readmission decision was made by a hospital psychiatrist. The court found that hospital personnel sometimes attempted to verify reasons given for an individual's return but were not required to do so.

Mr. Birl had suffered from a mental disorder for at least seven years and had been hospitalized at least ten times. He also frequently received treatment outside the hospital. Birl's trial visit was uneventful for almost three months; however, after he stopped taking medication on the advice of a local physician, he began to exhibit symptoms of disorder. After a visit to the mental health center, a recommendation for rehospitalization was entered and Birl was picked up at home by a police officer and returned to the hospital involuntarily. Birl was not given a reasonable opportunity to challenge the decision, either before he was reconfined or within a reasonable time thereafter. He received notice of the reasons for his reconfinement only when he specifically requested the information after his return. On his next trial visit, Birl filed suit seeking declaratory and injunctive relief against enforcement of the procedures for reconfining patients released on trial visits.

Using the *Morrissey* comparison, the court found similar characteristics of parole and trial visits:

First, both constitute a conditional release intended to permit the parolee or patient to demonstrate that he can function in society. "The parolee has been released from prison based on an evaluation that he shows reasonable promise of being able to return to society and function as a responsible, self-reliant person." [*Morrissey v. Brewer*, 408 U.S. 471, 482, 92 S. Ct. 2593, 2600.] Similarly, the trial visit is a "test of . . . ability to cope," according to Bryce Hospital's manual. Furthermore, both the parolee and the mental patient on trial visit enjoy considerable liberty.²⁸²

In light of the similarities between parole and trial visits, the court concluded *Morrissey* applied.

The court rejected the argument that no state action was involved because the mental health center which recommended rehospitalization was a private facility. Because the decision to readmit was made by a state hospital psychiatrist, and because the state's Department of Mental Health contracted with the community mental health centers, the court found the centers sufficiently involved with the state to be

281. Hospital policy granted temporary releases for a predetermined period of time, up to fourteen days, for therapeutic or recreational purposes. Temporary visit policies were not challenged by the plaintiff.

282. *Id.* at 490 (citing *Morrissey v. Brewer*, 408 U.S. 471, 482 (1972)).

considered state actors; thus, the fourteenth amendment applied and basic due process protections were required for the deprivation of liberty.

The court noted that, under the existing procedures, a patient released on a trial visit could be reconfined on the basis of an unconfirmed report by an unnamed person or because someone in a community mental health center disagreed with the diagnosis of the hospital psychiatrist who recommended the trial visit. The outpatient had no assurance that the decision to reconfine him would be made by someone reliable who knew him well and had frequent contact with him. The court concluded that, under the *Matthews v. Eldridge* balancing test, revocation presents a high risk of erroneous deprivation of liberty, and the outpatient has a private interest in avoiding unexplained or unnecessary reconfinelements. Further, the government's interest in reconfining a patient who has not committed any crime "and in fact may be guilty of nothing more than unusual or bizarre behavior . . . is relatively weak."²⁸³ Thus, due process requires that mental patients be given certain basic procedural safeguards before they are returned from trial visits. However, the court also recognized a possible private interest in assuring that prompt medical attention is available for recurring mental disorders. The court did not forbid rehospitalization, but found the record insufficient to determine what specific procedures are required. Stating that the task of identifying the proper procedures for reconfinement belongs primarily to the state, the court allowed the defendants an opportunity to submit a proposal.

The only subsequent major change made by the Department of Mental Health required an order from a probate judge before reconfinement would be permitted. The court found the changes insufficient because no guidelines were provided for a probate judge to determine whether reconfinement was warranted.²⁸⁴ The court noted that initial involuntary civil commitment requires notice, a hearing before a probate judge, the right to appear at the hearing, and the right to be represented by appointed counsel. Under the procedures and standards set forth in *Lynch v. Baxley*,²⁸⁵ and codified in the Alabama Code, an individual may be committed only if the probate judge finds the individual meets five criteria: 1) he is mentally ill; 2) as a consequence of mental illness, he poses a real and present threat of substantial harm to himself or others; 3) evidenced by a recent overt act; 4) treatment is available or confinement necessary to prevent substantial harm to the individual or others; and 5) commitment is the

283. *Id.* at 492.

284. 633 F. Supp. 707 (M.D. Ala. 1986).

285. 386 F. Supp. 378 (M.D. Ala. 1974)(three-judge court).

least restrictive alternative necessary and available.²⁸⁶

The court noted that the trial visit program is offered only to patients whose conditions have stabilized sufficiently and for whom hospitalization is no longer necessary, when a clinical determination has been reached that the patient can exist outside of the institution. In other words, the patient no longer meets the requirements for involuntary commitment. The court found that, at the time of Birl's release on trial visit, his condition was essentially the same as individuals who have been completely discharged and who could not be committed involuntarily; the only remaining question was "whether his condition would deteriorate to the point that confinement would once again be warranted."²⁸⁷ The policy premise that the initial commitment provides a sufficient basis for renewed confinement, *i.e.*, that new commitment procedures are not required because the individual has already been found to be in need of hospitalization, was considered by the court to be flawed.²⁸⁸

Citing decisions by the Supreme Court and circuit courts,²⁸⁹ the court concluded that continued confinement is constitutionally unjustifiable when an individual is no longer dangerous. When a patient has recovered to the point that his condition no longer satisfies the requirements for an initial commitment and he no longer presents a danger, he must be released—unconditionally. Because the decision to release a patient on a trial visit signifies the patient has been found nondangerous and in remission, the court would not allow a presumption of continuing mental illness during the trial visit to justify the rehospitalization procedures.

The court also rejected the argument that the hospital should be free to reconfine a newly released patient at the first sign of trouble so as to prevent either further deterioration in the patient's condition or possible danger to others:

An individual may not be involuntarily hospitalized as an initial matter based on a mere expectation of dangerousness, and there appears to be no reason why a return from trial visit based on mere expectations is any more permissible. . . . Certainly the hospital could not pick up and reconfine a fully discharged patient without going through initial commitment proceedings once

286. ALA. CODE § 22-52-10(a)(1984).

287. *Birl v. Wallis*, 633 F. Supp. 707, 710 (M.D. Ala. 1986).

288. *Cf. In re Stokes*, 546 A.2d 356 (D.C. 1988)(court has continuing responsibility to identify the least restrictive alternative for a patient when a revocation of outpatient commitment is sought by the hospital); *In re James*, 507 A.2d 155 (D.C. 1986)(trial court must make an explicit finding that inpatient treatment is the least restrictive alternative before revoking a patient's outpatient commitment).

289. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975)("even if [a mental patient's] involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed"); *Addington v. Texas*, 441 U.S. 418, 426 (1979)("the State has no interest in confining individuals involuntarily if they are not mentally ill or if they do not pose some danger to themselves or others").

again; nor may it do so with a patient released on trial visit.²⁹⁰

The court held that return from a trial visit is equivalent to an initial commitment and requires the same procedures established in *Lynch v. Baxley* for initial commitments.

C. Analysis

The view that dangerous patients require inpatient treatment and nondangerous patients should be released has been found among judges and community mental health center clinicians.²⁹¹ However, since deinstitutionalization moved treatment from the hospital to the community, many mentally ill persons who meet the criteria for involuntary treatment do not require inpatient hospitalization.²⁹² In fact, the dichotomy of treatment in a public institution or no treatment at all is a major flaw in most states' mental health delivery systems.²⁹³ Under statutes which require involuntary treatment in the least restrictive alternative, a mentally ill subject who is found to meet the criteria for involuntary treatment must be committed to the appropriate²⁹⁴ or available²⁹⁵ treatment which is least restrictive of her liberty. For some persons, hospitalization may be the least restrictive setting for a period of time. Others may require structured living arrangements, while still others need only outpatient treatment and supervision. Voluntary treatment is preferable to coerced intervention, but as long as society sees fit to involuntarily treat mentally ill persons,²⁹⁶ treatments which are the least restrictive of individual liberties are also desirable.

If persons who meet the standards for involuntary treatment are committed to an alternative setting, can they be hospitalized when

290. *Birl v. Wallis*, 633 F. Supp. 707, 711 (M.D. Ala. 1986)(citations omitted). See *Lynch v. Baxley*, 386 F. Supp. 378, 391 (M.D. Ala. 1974).

291. See *id.*; Miller & Fiddleman, *supra* note 23, at 149.

292. See Bachrach, *supra* note 2, at 6 (deinstitutionalization involves both depopulation of state mental hospitals and diversion of potential admissions to community-based facilities); Bachrach, *supra* note 25, at 1452.

293. See Bleicher, *Compulsory Community Care for the Mentally Ill*, 16 CLEV.-MARSHALL L. REV. 93 (1967)(dichotomy of hospitalization or release deprives some individuals of their liberty in the attempt to provide treatment, and deprives others of treatment in order to safeguard liberty interests); Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 409 (1983-84)(dichotomous system offers total freedom or total institutionalization).

294. *E.g.*, N.M. STAT. ANN. § 43-1-11.C (1989); N.D. CENT. CODE § 25-03.1-21 (1989); OKLA. STAT. ANN. tit. 43A, § 5-405.B. (West Supp. 1991); VT. STAT. ANN. tit. 18, § 7618(a)(1987).

295. *E.g.*, ALASKA STAT. § 47.30.755(b)(1984); ARIZ. REV. STAT. ANN. § 36-540.C (Supp. 1989); DEL. CODE ANN. tit. 16, § 5010(2)(1983).

296. *Cf.* Morse, *supra* note 20, at 57 ("involuntary commitment is a gravely unwise social institution, regardless of its constitutionality"); Szasz, *supra* note 1.

necessary because they have already been found dangerous? Are these patients less "dangerous" than patients who require inpatient treatment? They are, for practical purposes, in a situation similar to patients who are conditionally released—their liberty is conditioned upon not requiring inpatient hospitalization. The degree of freedom they enjoy is greater in the community than in an institution,²⁹⁷ but their freedom is not complete. Transfer to a more restrictive setting when the patient's condition changes effects a deprivation of liberty and also requires due process.²⁹⁸

Conditional release and outpatient commitment statutes which provide for summary revocation of outpatient treatment by the releasing facility or upon *ex parte* judicial order may violate the outpatient's due process rights. Many states' statutes may thus be unconstitutional under guidelines set forth in cases such as *Meisel v. Kremmens*, *In re True*, and *Birl v. Wallis*.²⁹⁹ Clearly, an outpatient treatment statute should provide procedural safeguards. The medical nature of the decision whether the outpatient requires immediate hospitalization—i.e., in an emergency—suggests that an in-community probable cause hearing before a neutral hearing officer, such as that required by *Morrissey v. Brewer* for parole revocations, is inappropriate.³⁰⁰

In the absence of an emergency, however, a hearing could be arranged in a hospital, community mental health center, the outpatient's home, or some other place convenient to the court or board and the outpatient.³⁰¹ When rehospitalization requires transporting the outpatient to another town or city, the disruption of the outpatient's life warrants providing a hearing prior to rehospitalization. However, the purpose of the hearing should not simply be a determination of whether the outpatient has failed to comply with the outpatient treatment plan. Statutes which allow revocation of outpatient treatment upon a finding of mere noncompliance or noncompliance "without good cause" are punitive in nature.³⁰² Hospitalization should not be

297. See *supra* note 218 and accompanying text.

298. *Id.*; *Eubanks v. Clarke*, 434 F. Supp. 1022 (E.D. Pa. 1977)(hearing required to transfer involuntarily committed patient to a more restrictive hospital).

299. See Note, *Constitutional Law: The Summary Revocation of an Involuntary Mental Patient's Convalescent Leave—Is it Unconstitutional?*, 33 OKLA. L. REV. 366, 368 n.12 (1980)(author suggests that the statutes of thirty-one states, as written at that time, may violate due process).

300. Some states include preliminary probable cause hearings as part of the involuntary commitment process, e.g., MINN. STAT. ANN. § 253B.07(7)(West 1982 & Supp. 1990); WASH. REV. CODE ANN. § 71.05.240 (1975 & Supp. 1990), but such provisions are not likely to apply to emergencies.

301. See HAW. REV. STAT. § 334-60.5(d)(1985)("Hearings may be held at any convenient place within the circuit"); OR. REV. STAT. § 426.095(1)(1989)(a commitment hearing may be held "in a hospital, the person's home or in some other place convenient to the court and the allegedly mentally ill person").

302. See e.g., IOWA CODE ANN. § 229.15(2)(West 1985)("If at any time the patient with-

used as a punishment for mentally ill persons who fail or refuse to comply with treatment,³⁰³ nor should preventive detention be used in anticipation of future dangerousness.³⁰⁴ The noncompliance with outpatient treatment must result in a deterioration of the patient's condition and a need for inpatient treatment before revocation is justifiable.³⁰⁵ Mentally ill persons who are "gravely disabled" should be provided the necessary assistance and services—in addition to support of family and social service agencies—through the use of volunteers,³⁰⁶ limited guardianships,³⁰⁷ and structured living arrange-

out good cause fails or refuses to submit to treatment as ordered by the court, . . . [the court] shall order the patient hospitalized . . . unless the court finds that the failure or refusal was with good cause and that the patient is willing to receive treatment . . ."); S.D. CODIFIED LAWS ANN. § 27A-9-28 (1984) ("If the individual ordered to undergo a program of treatment does not comply with the order, the board of mental illness shall conduct a hearing for the sole purpose of determining compliance or noncompliance, and if noncompliance is determined, the board may modify its original order and direct the individual to undergo an alternative program of treatment."); UTAH CODE ANN. § 62A-12-242(3)(a)(1989)(court shall find whether "the patient has failed to comply with a specified treatment plan to which the patient had agreed in writing").

The Court of Appeals of the District of Columbia has rejected the notion that a presumption of mental illness and dangerousness established by the original commitment allows a court to revoke an outpatient commitment when a patient fails to comply with the outpatient treatment plan:

A revocation of outpatient commitment based solely upon a patient's failure to comply with the prescribed course of outpatient treatment, without reliable evidence in the record that the patient is likely to be dangerous as a result of her mental illness, would violate the [District of Columbia Hospitalization of the Mentally Ill] Act. Further, . . . revocation of [James'] outpatient commitment would be impermissibly punitive in the absence of a finding that inpatient commitment was the least restrictive alternative.

In re James, 507 A.2d 155, 158 (D.C. 1986)(citations omitted). *Accord In re Stokes*, 546 A.2d 356, 363 (D.C. 1988).

303. Although therapeutic care might be possible in a hospital milieu, in practice, large public institutions are often inadequately funded and poorly staffed and residents are allowed little freedom of choice in the decisions of daily life.
304. *See People v. Nunn*, 108 Ill. App. 3d 169, 173, 438 N.E.2d 1342, 1344 (1982)(standard which requires the state to prove by clear and convincing evidence that an individual is in need of hospitalization is not satisfied where the individual might fail to take prescribed medication and present a danger to himself or others).
305. *See* MINN. STAT. ANN. § 253B.15(2)(West 1982 & Supp. 1990). *See supra* text accompanying note 277. *See also In re Stokes*, 546 A.2d 356, 363 (D.C. 1988)(outpatient's failure to take her medication is not, in and of itself, a basis for revocation of outpatient status); *People v. Nunn*, 108 Ill. App. 3d 169, 173, 438 N.E.2d 1342, 1344 (1982)(the refusal to take medication is not sufficient to justify an order of commitment).
306. Katkin, Zimmerman, Rosenthal & Ginsburg, *Using Volunteer Therapists to Reduce Hospital Readmissions*, 26 HOSP. & COMMUNITY PSYCHIATRY 151 (1975).
307. *E.g.*, ARIZ. REV. STAT. ANN. § 36-540.H (1986 & Supp. 1989)("If upon finding that a patient is gravely disabled, the court also finds that the patient is in need of immediate guardianship for the purpose of protection of the patient or for the purpose of carrying out alternatives to court-ordered treatment, the court may

ments³⁰⁸ to allow them to live in the community.

Some states have elaborate procedures for revocation of conditional releases from inpatient treatment. For example, in Tennessee, "the parent, guardian, spouse, responsible adult relative, or treating professional of a patient, the person who initiated the commitment proceedings of the patient, or the head of the discharging facility" may file an affidavit with the appropriate court if an outpatient is, "without good cause," not complying with the treatment plan and the treating professional believes the outpatient will not comply voluntarily.³⁰⁹ If the affidavit was filed by the treating professional and the outpatient does not appear before the court, the sheriff transports the patient to the releasing facility, where the patient is temporarily recommitted.³¹⁰ If the affidavit was filed by someone other than the treating professional and the patient does not appear before the court, the patient is taken to the treating professional or a community mental health center for examination. If the professional finds the outpatient is not complying, without good cause, and is not likely to comply, the outpatient is returned to the releasing facility under a temporary recommitment and a hearing is scheduled.³¹¹ If the outpatient appears before the court, a hearing is held to determine whether the outpatient is, without good cause, not complying with the treatment. If the court finds the outpatient either cannot be put in compliance immediately or will not stay in compliance without hospitalization, the patient is recommitted to the releasing facility.³¹² If an outpatient is rehospitalized for noncompliance after a hearing, "upon readmission the patient shall be held under the authority of the original court order of commitment."³¹³ Because no finding of present dangerousness is made and the initial commitment is relied upon for authority to rehospitalize, Tennessee's statute appears directly contrary to *Birl v. Wallis*.³¹⁴

appoint a temporary guardian. . . ."). Use of representative payees or adult protective services would allow assistance to be limited to specific functions in accordance with individual needs.

308. In most communities, there exists a need for a range of residential services, such as group homes and intermediate care facilities which can allow residents as much freedom as each is capable of handling, and can provide structure and supervision according to individual needs.

309. TENN. CODE ANN. § 33-6-202(1)(1984 & Supp. 1989).

310. *Id.* at § 33-6-204(a)(Supp. 1989).

311. *Id.* at § 33-6-204 (Supp. 1989).

312. *Id.* at § 33-6-203(d)(Supp. 1989).

313. *Id.* at § 33-6-206 (Supp. 1989).

314. *See also, e.g.,* MINN. STAT. ANN. § 253B.15(1)(West 1982 & Supp. 1990) ("The head of the treatment facility may provisionally discharge any patient without discharging the commitment, unless the patient was found . . . mentally ill and dangerous to the public."); UTAH CODE ANN. § 62A-12-241(2)(a)(1989) (The clinical director of the mental health facility "is authorized to issue an order for the immediate placement of a patient not previously released from an order of hospitalization into a more restrictive environment . . ."); W. VA. CODE § 27-7-4

States cannot "define away" the problem by conferring authority to rehospitalize patients under an original commitment order if that authority cannot constitutionally be granted.

The *Birl* court's view that automatic rehospitalization of conditionally released patients is unjustifiable because they no longer meet the commitment criteria may be correct insofar as many conditional release statutes allow involuntary³¹⁵ rehospitalization after long periods of time³¹⁶ without a full hearing and in the discretion of mental health professionals.³¹⁷ Conditional release into the community from inpatient treatment is hardly a "trial visit" after several months without incident. As the court in *Birl* required, a patient who is no longer dangerous must be unconditionally released.³¹⁸

However, mental health professionals may not always know whether a patient who appears stable in a structured environment will adjust to community life—the individual is often returned to circumstances which may have precipitated the onset of an acute episode. In Oklahoma, for example, convalescent leave is granted rather than discharge when "the patient's complete recovery can be determined only by permitting him to leave the facility."³¹⁹ Thus, hospital professionals should be allowed some discretion in granting trial visits for several days and conditional releases for limited periods of time.³²⁰ At

(1986)(involuntary patients on convalescent leave "may be readmitted to the mental health facility on the basis of the original commitment").

315. Of course, patients who recognize the need for hospitalization and voluntarily seek treatment should be permitted readmission.

316. *E.g.*, FLA. STAT. ANN. § 394.469(3)(West 1986)(one year). ILL. ANN. STAT. ch. 91 1/2, para. 4-702(b)(Smith-Hurd 1987)(conditional discharge for one year; can be extended one year); IOWA CODE ANN. § 226.23 (West 1985)(convalescent leave up to one year); KAN. STAT. ANN. § 59-2924(d)(1983 & Supp. 1989)(indeterminate); MICH. COMP. LAWS ANN. § 330.1479 (1980 & Supp. 1988)(director shall discharge any patient who has been on authorized leave or absence from the hospital for a continuous period of one year); MINN. STAT. ANN. § 253B.15(1)(West 1982 & Supp. 1990)(provisional discharge shall terminate on the date specified in the aftercare plan unless revoked or extended); OKLA. STAT. ANN. tit. 43A, § 7-101(B)(West Supp. 1990)(patient who has not been returned to releasing facility within twelve months of granting of convalescent leave is discharged).

317. *See supra* notes 73-74.

318. *See also* Note, *supra* note 299, at 382:

[I]f the state hospital director believed that the patient was well enough to leave the hospital without endangering himself or others, and the patient has not been rehospitalized while on leave, then logically it can be assumed that treatment has been successful. The patient has proved that he is no longer dangerous and can live in society. Thus, even though the patient may continue to be mentally ill, he no longer meets the statutory requirements for commitment.

319. OKLA. STAT. ANN. tit. 43A, § 7-101 (West Supp. 1990).

320. *See* IMDL SUPPLEMENT, *supra* note 16, Guideline H.3(b) ("If, at any time during a period of court-ordered commitment to an inpatient or outpatient mental health facility, a respondent's condition improves but the respondent remains in need of involuntary mental health services less restrictive than those provided by the fa-

the end of the period of conditional release, a patient who did not require inpatient treatment would be unconditionally discharged and rehospitization would require a new commitment order. Outpatient commitment proceedings could be initiated if the individual would likely benefit from continued treatment and meet the criteria for outpatient commitment.³²¹

IV. CRITERIA FOR INVOLUNTARY COMMITMENT

A. The Dangerousness Standard

In 1961, Lindman and McIntyre considered the issue of hospitalization of nondangerous mentally ill persons to prevent their condition from deteriorating, particularly patients such as manic depressives and schizophrenics who could become dangerous without treatment:

Although it may be desirable from a medical point of view to hospitalize those who are not presently dangerous but who might easily become so in the absence of proper treatment, the question of the propriety of such hospitalization remains a real one in view of the conditions existing in many hospitals. A prime requisite for the success of such a policy is that the hospitals are equipped to offer the care and treatment required by such patients. Many communities have not yet provided the financial resources essential to the establishment and maintenance of such facilities. In the absence of such facilities, of course, there is no justification for broadening the involuntary hospitalization requirements to include nondangerous persons.³²²

Nearly fifteen years later, the United States Supreme court held in *O'Connor v. Donaldson* that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."³²³ Although this ambiguous holding may be taken to mean that a state cannot confine a nondangerous mentally ill person unless adequate treatment is provided, many lower courts interpreted *Donaldson* to mean that involuntary civil commitment statutes which do not require proof of dangerousness as well as mental illness are unconstitutional.³²⁴ Accordingly, courts struck

cility, the [treatment professional] should effect a transfer to a less restrictive facility or a conditional release . . . , which may include outpatient treatment and care or a combination of outpatient and inpatient treatment and care"). In some states, the conditional release terminates when the period of involuntary commitment ends. Thus, if a patient is committed for a 90-day period and is hospitalized for 60 days, he may be conditionally released for the remaining 30 days. *See, e.g.,* MO. ANN. STAT. § 632.385(2)(1988 & Supp. 1990).

321. *See infra* Section IV. B.

322. THE MENTALLY DISABLED AND THE LAW 20 (F.T. Lindman & D.M. McIntyre ed. 1961).

323. *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

324. *See, e.g.,* Suzuki v. Yuen, 617 F.2d 173 (9th Cir. 1980); Doe v. Gallinot, 486 F. Supp. 983 (C.D. Cal. 1979); Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424 (D. Utah 1979).

down statutes which permitted commitment based solely on standards of "in need of treatment" or "in the best interest of the patient."³²⁵ Statutory revisions resulted in adoption in most jurisdictions of a commitment standard requiring dangerousness to others or dangerousness to self, which may encompass inability to care for basic needs (gravely disabled).³²⁶

Recently, some states, in a shift back to reliance on *parens patriae* powers, have broadened their commitment criteria to allow involuntary treatment of mentally ill persons whose condition will deteriorate without treatment.³²⁷ As treatment in settings less restrictive than inpatient hospitalization becomes more widely available, the issue is again raised of the propriety of involuntary commitment of mentally ill persons who are not currently dangerous and who would not be committable under police power standards.³²⁸

325. See, e.g., *Johnson v. Solomon*, 484 F. Supp. 278 (D. Md. 1979); *Goldy v. Beal*, 429 F. Supp. 640 (M.D. Pa. 1976); *Stamus v. Leonhardt*, 414 F. Supp. 439 (S.D. Iowa 1976).

326. See *supra* note 5. State statutes, and judicial interpretations, vary in their definitions of "dangerous". A number of states require evidence of a recent overt act indicating dangerousness, e.g., ALA. CODE § 22-52-10(a)(3)(1975); OKLA. STAT. ANN. tit. 43A, § 1-103(n)(1)(West Supp. 1990). Pennsylvania requires "clear and present danger of harm to others" or the patient. PA. STAT. ANN. tit. 50, § 7301(a)(Purdon Supp. 1990). In addition to dangerousness to self or others, many states allow involuntary commitment of mentally ill persons who are unable to provide for basic needs, e.g., KAN. STAT. ANN. § 59-2902(g)(2)(Supp. 1989); MICH. COMP. LAWS ANN. § 330.1401(b)(West 1980); MINN. STAT. ANN. § 253B.02(13)(West 1982 & Supp. 1990) ("failure to obtain necessary food, clothing, shelter or medical care"); MO. ANN. STAT. § 632.005(9)(Vernon 1988 & Supp. 1990); OKLA. STAT. ANN. tit. 43A, § 1-103(n)(2)(West Supp. 1990), or who are gravely disabled, e.g., ALASKA STAT. § 47.30.735(c)(1984); ARIZ. REV. STAT. ANN. § 36-540(A)(1986 & Supp. 1989).

In Nebraska, a mentally ill dangerous person is defined as any mentally ill, alcoholic, or drug abusing person who presents:

- (1) A substantial risk of serious harm to another person or persons within the near future as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or
- (2) A substantial risk of serious harm to himself or herself within the near future as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm or evidence of inability to provide for his or her basic human needs, including food, clothing, shelter, essential medical care, or personal safety.

NEB. REV. STAT. § 83-1009 (1987).

327. See *Durham & La Fond*, *supra* note 31, at 399.

328. See *id.* at 401 (involuntary commitments in Washington increased significantly and included many patients who had no previous contact with state hospitals after commitment law was broadened). Geller, *supra* note 11, at 1261, argues that the Massachusetts involuntary commitment standard, which requires a "likelihood of serious harm" is satisfied by mere discontinuation of medication by patients with a history of deterioration and dangerousness. However, unless Massachusetts case law has interpreted the statutory definition of likelihood of

B. A Lower Standard for Outpatient Commitment?

Most states which allow commitment to outpatient treatment as an alternative disposition require the same standard as that required for inpatient commitment. Thus, the committing agency first determines whether an individual meets the statutory criteria for involuntary commitment and then a treatment disposition is determined, much as a finding of guilt precedes sentencing for criminal offenders. For example, in Virginia, persons who meet the criteria for involuntary treatment but who are not in need of hospitalization may be subject to court-ordered outpatient treatment.³²⁹

Under some statutes, after the initial finding of involuntary commitment, specific criteria must be satisfied before outpatient treatment may be ordered. In Arizona, if the court finds by clear and convincing evidence that a mentally ill person is a danger to himself or others or is gravely disabled and in need of treatment and is either unwilling or unable to accept voluntary treatment, the court may order the person to undergo a program of outpatient treatment, inpatient treatment, or a combination program of inpatient and outpatient treatment.³³⁰ However, outpatient treatment or combined inpatient and outpatient treatment may be ordered only if the court finds that the patient: (a) does not require continuous inpatient hospitalization; (b) will be more appropriately treated in an outpatient treatment program (or combination program); (c) will follow a prescribed outpatient treatment plan; and (d) will likely not become dangerous or suffer more serious physical harm or serious illness if he follows a prescribed

serious harm very broadly, the discontinuation of medication alone does not appear sufficient. MASS. GEN. LAWS ANN. ch. 123, § 1 (West 1986 & Supp. 1990) defines likelihood of serious harm as:

(1) a substantial risk of physical harm to the person himself *as manifested by* evidence of, threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons *as manifested by* evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself *as manifested by* evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

(emphasis added). Broadening of statutory criteria to include anticipation of future dangerousness should be clearly delineated by legislatures, not adopted by practitioners. Dr. Geller does not disagree; at the end of his article he notes: "without clear statutes governing community-based, coercive treatment, both patients and practitioners may be vulnerable to idiosyncratic resolutions These imposed therapeutic interventions will vary significantly across the continua of legal rights, clinical efficacy, and basic respect for individuality." Geller, *supra* note 11, at 1263.

329. VA. CODE ANN. § 37.1-67.3 (1984 & Supp. 1990).

330. ARIZ. REV. STAT. ANN. § 36-540.A (1986 & Supp. 1989).

outpatient treatment plan.³³¹ In Michigan, an involuntarily committed person who "has been hospitalized involuntarily 2 or more times within the 2-year period immediately preceding the filing of the petition" and who has rejected aftercare programs and treatment must be ordered to undergo a program of combined hospitalization and alternative treatment.³³²

A few states which include a separate statutory scheme for involuntary outpatient commitment provide a lower standard for outpatient commitment than is required for inpatient commitment. North Carolina statutes define the criteria for outpatient commitment to require "clear, cogent and convincing" evidence of mental illness; capability of surviving safely in the community with available supervision from family, friends or others;³³³ a treatment history indicating a need for treatment to prevent further disability or deterioration which "would predictably result in dangerousness"; and inability to make an informed decision voluntarily to seek or comply with recommended treatment.³³⁴

Similarly, in Hawaii, outpatient commitment may be ordered if the family court finds that an individual is (1) suffering from a severe mental disorder; (2) is capable of surviving safely in the community with supervision; (3) "at some time in the past: (A) has received inpatient hospital treatment for a severe mental disorder . . . or (B) has been imminently dangerous to self or others as a result of a severe mental disorder"; (4) based on treatment history and current behavior, the person is now in need of treatment in order to prevent a relapse or deterioration which would predictably result in the person's becoming imminently dangerous; (5) the person is unable to make an informed decision to seek or comply with recommended treatment; and (6) there is a reasonable prospect that outpatient treatment will be beneficial.³³⁵

Georgia also allows outpatient commitment of mentally ill persons who do not meet the inpatient criteria. An "outpatient" is defined as a person who is mentally ill and "is not an inpatient but who, based on the person's treatment history or current mental status, will require outpatient treatment in order to avoid predictably and imminently becoming an inpatient" and who, because of current mental status, mental history, or nature of mental illness is unable to seek or comply voluntarily with outpatient treatment and is in need of involuntary

331. *Id.* at § 36-540.B.

332. MICH. COMP. LAWS ANN. § 330.1468(4)(West Supp. 1990).

333. Note the similarity in language to the Supreme Court's holding in *O'Connor v. Donaldson*, 422 U.S. 563 (1975). See *supra* note 323 and accompany text.

334. N.C. GEN. STAT. § 122C-271 (a)(1)(1989).

335. HAW. REV. STAT. § 334-121 (1985).

treatment.³³⁶

A lower standard for outpatient commitment may allow early, or continuing, treatment of discharged or never-hospitalized chronic patients and consequently may prevent decompensation or worsening of the individual's condition. Services could be provided to patients who otherwise would be left on their own without adequate resources or support. However desirable aftercare services may be, the critical issue is the stage at which coercive beneficence is justifiable.

In light of the imprecision of psychiatric diagnoses³³⁷ and improper use of medications (as well as the history of institutional abuses of the mentally handicapped), vague standards allowing professional judgments about patients' "need" for treatment and "inability" to make the "correct" decision to accept treatment may be eyed suspiciously.³³⁸ On the other hand, the Supreme Court has, in recent years, granted great deference to the professional judgment of qualified mental health professionals.³³⁹ If the Supreme Court's holding in *Donaldson* is read to mean that a state cannot constitutionally *institutionalize* a nondangerous mentally ill person, then involuntary outpatient commitment of currently nondangerous mentally ill persons, with lesser restrictions on liberty, may be constitutionally permissible. *Birl v. Wallis* is not contrary to this view; the court in *Birl* objected to the rehospitalization of outpatients without a due process determination of the dangerousness required for confinement.

Thus, if hospitalization upon noncompliance is not permitted, a lower standard for outpatient commitment may be acceptable for the class of individuals who have a long history of chronic mental illness and of failure to comply with aftercare treatment after being stabilized and released from involuntary treatment or hospitalization. Once dangerousness has been demonstrated and the state has exercised its legitimate authority in committing the individual, continued supervision by the state for a limited period of time³⁴⁰ on outpatient status may be justified if a high likelihood exists of a return to a "dan-

336. GA. CODE ANN. § 37-3-1(12.1)(Cum. Supp. 1987).

337. See Morse, *supra* note 20, at 68-71.

338. See, e.g., *United States v. Charters*, 829 F.2d 479, 495-96 (4th Cir. 1987)(citing Morris, *Dr. Szasz or Dr. Seuss: Whose Right to Refuse Mental Health Treatment*, 9 J. PSYCHIATRY & L. 283, 290 (1981)(deciding whether a patient is competent by determining whether he agrees with the psychiatrist's proposed treatment undermines the concept of patient autonomy and abrogates the right to refuse treatment)), *vacated*, 863 F.2d 302 (4th Cir. 1988)(en banc), *cert. den.*, 110 S. Ct. 1317 (1990).

339. See *Youngberg v. Romeo*, 457 U.S. 307 (1982).

340. An outpatient commitment statute might allow involuntary outpatient treatment for 60 days (e.g., ILL. ANN. STAT. ch 91 1/2, para. 3-813(a)(Smith-Hurd 1987)), 90 days (e.g., ALASKA STAT. § 47.30.770 (1984); MONT. CODE ANN. § 53-21-127(2)(b)(1989); N.C. GEN. STAT. § 122C-271(a)(1989)), or six months (e.g., HAW. REV. STAT. § 334-127 (1985); OR. REV. STAT. § 426.130(2)(1989)).

gerous" condition without continuing treatment, even though the individual is not currently dangerous or in need of hospitalization. However, such statutes should require a history of involuntary treatment and demonstrated dangerousness within the recent past, and not a history of hospitalization.³⁴¹ As treatment moves into the community, newer chronic patients might never require hospitalization.

A different situation exists when the individual is being considered for outpatient commitment, not after a long period of inpatient treatment, but as a less restrictive alternative to inpatient treatment, as in an initial commitment order. Arguably, early treatment of a first episode may allow the individual to remain in the community and thus minimize disruption of his life as well as avoid the labelling and stigma often attached to institutionalization. However, there is a danger that committing agencies will commit to outpatient treatment individuals who do not meet the standard for inpatient treatment because they believe the individual needs some treatment and the restrictions on liberty occasioned by outpatient commitment are less onerous.³⁴² Such practices would expand the reach of the state's commitment authority to include individuals who have not previously been treated in the state's mental health system.³⁴³ Such individuals might be willing to seek treatment voluntarily at an early stage when they may be more capable of recognizing the need. Thus, a lower standard for outpatient commitment may be justified for the chronically mentally ill but not for allegedly mentally ill persons who have never been proven dangerous, by whatever interpretation of dangerousness used. For nonchronic patients, commitment to outpatient treatment could still be ordered as a less restrictive alternative to inpatient treatment for persons who satisfy the standard commitment criteria of mentally ill and dangerous.

341. See Minkoff, *supra* note 6, at 946 ("As deinstitutionalization has become more 'successful,' it has become increasingly the norm for people with chronic mental illness to spend the major portion of their lives in the community and never to become institutionalized in a state hospital"). Cf. Michigan's criteria, *supra* note 332 & accompanying text.

342. Cf. *supra* note 43.

343. See Durham & La Fond, *supra* note 31. Most outpatient commitment laws are designed to reach chronic patients, see Hiday and Scheid-Cook, *supra* note 23, at 215-16, rather than widen the net to subject additional persons to involuntary treatment. Early interventions should endeavor to keep nonchronic persons out of the commitment system rather than seeking to draw them in. See CAPLAN, *supra* note 8, at 105 ("In order to make a significant contribution to the reduction of prevalence, treatment must be not only early but also successful." A patient is more likely to respond to early treatment, before "the disorder has become buttressed by the patient's entire life situation and he has learned to profit from the secondary gratifications and dispensations of the patient role").

V. CONCLUSION: SUMMARY AND RECOMMENDATIONS

Involuntary outpatient treatment may be provided to mentally ill persons pursuant to either conditional release or outpatient commitment statutes. In general, conditional release procedures allow the director of an inpatient facility to release hospitalized mentally ill persons to outpatient treatment on specified conditions. If the patient fails to comply or adjust in the community, the release can be revoked at the director's discretion. Such provisions have come under attack for failure to provide outpatients due process by ensuring that the revocation is necessary.

Outpatient commitment is ordered by a court or mental health board following a period of inpatient treatment or as a less restrictive alternative to inpatient treatment. Procedural protections are usually provided, although some states allow revocation upon mere noncompliance, without requiring a showing of need for inpatient treatment. Anticipation of predictable dangerousness of chronic mental patients who have a history of decompensation and dangerousness when treatment is discontinued may justify involuntary outpatient treatment, but hospitalization requires a showing of present dangerousness.

Studies of the effectiveness of outpatient commitment indicate that outpatient commitment can be successful in maintaining chronically mentally ill individuals in the community.³⁴⁴ Outpatient commitment has been shown to be effective in both increasing compliance with aftercare programs—even after the period of outpatient commitment has ended³⁴⁵—and reducing hospital readmission rates.³⁴⁶

One reason for the dearth of outpatient commitments in Nebraska may be the failure of the Nebraska Mental Health Commitment Act to provide specific guidelines for outpatient commitment or for revocation or modification of the outpatient treatment order if an outpatient does not comply with treatment. Another reason might be a lack of available treatment programs or community mental health center therapists who are willing or able to provide active outreach and monitoring of clients.³⁴⁷

Judges and mental health professionals involved in the mental health system often advocate strict provisions for enforcing outpatient commitment orders and dealing with noncompliance by outpatients.³⁴⁸ However, patients must be protected from the potential

344. See Hiday & Scheid-Cook, *supra* note 163.

345. See Hiday & Scheid-Cook, *supra* notes 23 & 163; Van Putten, Santiago & Berren, *Involuntary Outpatient Commitment in Arizona: A Retrospective Study*, 39 HOSP. & COMMUNITY PSYCHIATRY 953 (1988).

346. Hiday & Scheid-Cook, *supra* note 163. *But see* Bursten, *supra* note 23.

347. *Cf.* Miller & Fiddleman, *supra* note 23.

348. See INVOLUNTARY OUT-PATIENT COMMITMENT, *supra* note 48; Hiday & Scheid-Cook, *supra* note 23, at 218.

abuses of allowing unchecked discretion³⁴⁹ or from being hospitalized when their conditions do not warrant inpatient treatment. Likewise, outpatient commitment should not be used simply as a mechanism for forcible medication. Outpatient commitment may be most appropriate for gravely disabled persons who need assistance in housing, money management and independent living as well as mental health treatment by providing a justification for involuntary intervention and monitoring.

The chronically mentally ill outpatient should be committed to a designated treatment facility and/or professional, with a treatment plan filed with the committing agency. Because the person is not committed to an inpatient facility, there is no hospital to which to "return" the noncomplying outpatient. As in North Carolina and Hawaii, outreach efforts, including home visits when necessary, should be required to encourage compliance. Transportation should be arranged for treatment appointments if necessary. Because many chronically mentally ill persons are unable to support themselves, medications should be readily available at minimal or no cost.³⁵⁰

If efforts to obtain compliance fail, the treating professional or director of the facility should petition the court or mental health board for an order directing a peace officer to transport the outpatient to the outpatient treatment facility for examination.³⁵¹ In an emergency, the outpatient could be hospitalized for a limited period of time, *e.g.*, thirty-six hours, at the discretion of the designated outpatient treatment professional or another qualified mental health professional, with an affidavit describing the reasons for the hospitalization submitted to the committing agency. The court could order continued detention of the patient pending a hearing only if the court finds that hospitalization is necessary to avoid serious imminent harm to the patient or others. Otherwise, the patient would be returned to the community and revocation could be sought if continued inpatient treatment was believed necessary.

If, upon examination, the professional determines that the outpatient is not in need of immediate treatment, the professional should

349. See Mulvey, Geller & Roth, *supra* note 34, at 575 ("When benevolent treatment and coercion operate together, it seems that coercion becomes pervasive whereas treatment remains nominal").

350. See CAPLAN, *supra* note 8, at 122-23.

351. See *supra* note 200 & accompanying text; Miller & Fiddleman, *supra* note 23, at 150-51:

Outpatient commitment statutes should contain provisions authorizing the transportation of noncompliant patients directly to the facilities to which they were committed, rather than back to inpatient facilities. . . . Rehospitalization interrupts the patient's community treatment unnecessarily and provides too convenient an escape valve for CMHC staff who are reluctant to deal with involuntary patients.

provide and encourage treatment, but should not forcibly medicate the outpatient. The peace officer should then return the outpatient to the community, and if the professional believes the outpatient is showing signs of deterioration and refuses outpatient treatment, the professional may petition the committing agency for a hearing for revocation or modification of the outpatient order.³⁵² The outpatient would remain in the community and receive sufficient notice of the hearing. His attorney and any other interested persons should also be notified. By requiring "all reasonable efforts" to obtain compliance and not allowing automatic hospitalization, not only will the outpatient's due process rights be protected, but outpatient treatment providers will be forced to make a commitment to treating the outpatient and will not have available the alternative of simply returning difficult patients to the hospital.

At the hearing, the burden of proof should be on the party seeking revocation. The committing agency could revoke if it found a change in the outpatient's condition (whether resulting from noncompliance or not) such that she is imminently dangerous to herself or others and requires more restrictive treatment. The court should periodically review each outpatient's progress under the outpatient treatment plan and be permitted to discharge patients who are not benefitting from involuntary treatment. Voluntary outpatient treatment should be encouraged, with similar provision of transportation, medication, and outreach efforts when necessary. Such efforts should perhaps be tried before resorting to involuntary proceedings.

Conditional release from hospitalization could be allowed for a limited period of time, such as thirty days. The releasing facility should file an outpatient treatment plan with the committing agency for review prior to release. Any return of the patient to the institution during the period of conditional release would require the facility to notify the court or mental health board and the patient and his attorney of the reasons for the rehospitalization within twenty-four hours. If the committing agency finds the supporting basis insufficient, the hospital may request a hearing or release the patient. If the committing agency approves the return and revokes the conditional release, the patient would also have the right to request a hearing.

If outpatients cannot be forcibly medicated or automatically hospitalized, one may question the value of a separate procedure for outpatient commitment. A judicial finding of a need for outpatient commitment may provide a justification for the intrusiveness occasioned by outreach efforts for an outpatient who knows he is required

352. The outpatient treatment order would be revoked if inpatient and outpatient procedures are separate, *see supra* note 82 and accompanying text. The order could be modified to require inpatient treatment or other alternative treatment if outpatient treatment was a dispositional alternative. *See supra* Section III.A.

by court order to receive treatment. Some patients will be more likely to comply with aftercare or outpatient treatment, either because of the court order itself or because of the greater involvement of mental health professionals. Monitoring of the patient's condition permits early intervention upon deterioration, before the individual causes disruption or damage. Further, inpatient facilities may be more willing to release some patients earlier if patients will continue to receive treatment. Mulvey, Geller, and Roth suggest that outpatient commitment is "worth attempting" because:

[Outpatient commitment] is a possible way to get us out of the present quandary of having to decide between the inhumaneness of institutions and the neglect involved in dumping mental patients in the community. The use of an element of coercion should make us wary of the dangers of this approach, but the unsuitability of our present options should push us to design a system that is sensitive to both the needs and the rights of mental patients.³⁵³

Disabled mentally ill persons who are not dangerous to themselves or others should be provided the assistance they need to survive in the community.³⁵⁴ Broadening the group of individuals who may be treated against their will can have serious, often unintended, consequences for a state's mental health system.³⁵⁵ Further, treatment is generally available on a voluntary basis;³⁵⁶ although some persons, because of the nature of their illness, might refuse to seek help, society is not thereby "denying" them treatment by not forcing it upon them.³⁵⁷ The solution to the problems of the homeless mentally ill is not to send them back "home" to the institution. The "failure" of deinstitutionalization may be attributed, not to ideological deficiencies, but to implementation issues, inadequate funding and continued reliance on institutional care.³⁵⁸ If the number of individuals involuntarily committed increases, alternatives to inpatient hospitalization will need to be considered as facilities become overcrowded. The additional funding which would undoubtedly be needed under an approach suggesting more treatment for more persons would be better spent in strengthen-

353. Mulvey, Geller & Roth, *supra* note 34, at 582.

354. See Mulvey, Geller & Roth, *supra* note 34, at 577 ("No therapeutic alliance or empowerment is likely to occur in [a clearly monitoring] relationship. Efforts would be better spent providing for the basic needs of these individuals and working toward positive relationships through pro-active outreach programs"). Cf. Lewis & Hugi, *supra* note 31 at 216 (interviews with former patients indicated that for some patients readmission may be purposeful behavior to obtain resources such as housing, food and companionship which ex-patients often lack).

355. See Durham & La Fond, *supra* note 31.

356. But see *id.* at 401 (change in commitment law resulted in extreme overcrowding in state hospitals such that voluntary patients were virtually excluded).

357. Cf. *supra* note 21 and accompanying text.

358. See *Deinstitutionalization of the Mentally Ill, Hearing Before the Subcommittee on Fiscal Affairs and Health of the Home Committee on the District of Columbia, 97th Congress, 1st Session 155-67 (1981)* (testimony of John Talbott, M.D., Professor of Psychiatry, Cornell University Medical College).

ing community and residential services. If the Nebraska legislature is determined to relax the criteria for involuntary civil commitment, such efforts should be limited to reaching those individuals who are not adequately served under the current approach. A lower standard for outpatient commitment of the chronically mentally ill only would be preferable to a lower standard for all involuntary commitments.